THE MODERN HOSPITAL

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HOW MAY HOSPITAL CARE BE FURNISHED TO PERSONS WITH MODERATE INCOMES?*

By GEORGE B. SOMERS, M.D., Director, Lane and Stanford University Hospitals, San Francisco, Cal.

The increased cost of medical services has made more serious the problem of hospital care for those who cannot afford to pay the standard prices set for such care. The situation can be met only by a means of extending these services to the patient at a reduced cost without reducing professional incomes. This calls for a reorganization of hospital management and the adoption of some form of group work in medical and nursing services. In practice, such changes mean a deficit to be met by the hospital. The problem thus becomes one of meeting the deficit by one of the three suggested methods: by increasing rates of full-pay patients, by endowments, and by community aid in wiping out deficits.

THE topics which are covered in this discussion relate not only to the hospital budget administration, but the parallel and even higher percentage in cost of professional attention. As a matter of fact, the high cost of hospital care depends largely on the needs and demands of the doctor for expensive equipment and service in pursuing modern methods of diagnosis and treatment. In fairness to the hospital the responsibility of each should be clearly understood. There is little use in reducing the cost of the one without regulating the other. Let us take up the professional situation first and dispose of its problems.

Exit the Family Physician

In comparison with former family expenses for medical service, the present cost of professional attention is high. The reason for this is found in the rapid and extraordinary advance in scientific medicine which requires skilled specialists to execute its processes. The difference may be compared to the equipment of the family physician which was limited almost to a pencil and paper, and the numerous instruments and precise apparatus of the present day. Consideration of the training of the latter specialist and the maintenance of his equipment leads to an appreciation of the high cost of his professional service.

Other necessities of life have also become expensive, but we may deny ourselves of them if we prefer to do so. Matters which affect health are among the inalienable rights of all the people, together with life, liberty and the pursuit of happiness. Though not perhaps in words, it is a widespread but subconscious conviction that the right to good health belongs in this list. The high cost of safeguarding health has therefore, perhaps without our being fully aware of it, become a question having both political and economic bearings, and is a direct factor in obstructing public health measures. The situation may be explained in the following summary.

The rise of the specialist has displaced the family physician. The breaking into the traditional methods of practice has not yet been adjusted in a measure to place the benefits of advanced medicine within the reach of all. The rich and the poor are provided for, but scientific medicine comes dangerously near being a monopoly of these two classes. People of moderate means are often unable to enjoy its benefits. In view of this fact it is clear that in the absence of the family

*Read before the third annual conference of the hospitals of California, held under the auspices of the League for Conservation of Public Health, October 18, 1923, San Francisco, Cal.

physician at a moderate cost, and through failure to provide a substitute with the attributes of scientific medicine, a large number of people have given up their allegiance to regular medicine and have become supporters of low priced but irregular and irresponsible cults and schools, which have grasped the opportunity of capitalizing the field of low cost treatment of ill health.

Rise of Irregular Schools

Furthermore, in order to strengthen their position and their hold upon the community, these influences have organized themselves, have injected their interests into politics, and have stimulated opposition to the regular profession.

If high costs or neglect of the welfare of any portion of the community are in any way responsible for this situation, it is high time that steps were taken to remove the unreasonable and prejudiced opposition to scientific medicine which injures the opponent more than the opposed, and is a detriment to public health. Means should be provided to the end that no one may complain that he is denied the benefits of medical science.

Medical Services on a Business Basis

As for ways and means of providing such service, the solution lies with the medical profession itself. I wish to state in the beginning that there is no question of socialized medicine involved in the solution, unless the medical profession fails to keep the remedies within their own control. I am of the opinion that low cost medical service may be provided in a business-like way and yet along strictly ethical lines: that in spite of the scarcity of professional men the benefits of regular medicine may be extended to a very much larger number of people and at the same time without reducing professional incomes or interfering with the present professional fees paid by patients who are able to afford them.

The answer, to my mind, lies in organization. Without going into the matter in detail it may be stated that the nucleus of the solution has already been tried out by what is called group medicine, or better described, as diagnostic groups.

This method of extending the benefits of regular medicine is well known within the profession itself but has never been formally recognized or taken up as a definite function or responsibility of state and county medical societies.

One of the most serious aspects of the situation is the necessity of providing good hospital treatment at a lower rate. It is readily apparent that in order to reduce rates it is essential to lower the cost of maintenance and operation or else find a good angel to meet the deficit.

The problem of reducing costs may be considered from two angles, the theoretical and the practical. Theoretically, we should have to start with a clean slate and recast the entire hospital process in the light of our present knowledge and experience. In order to reach the economic ideal we should build hospitals of low cost and small overhead expense. Design them with uniform accommodations and with special study of economic upkeep, apportion the size of plant to the needs of the community, building them neither too large nor too small; equip them moderately and substantially, organize the administrative staff with an eye to efficiency in all departments and, above all things, organize the visiting doctors to the end that they become aids and an administrative asset rather than a source of extravagant demands, lavish waste of supplies and unreasonable complaints. Fortunate indeed is the hospital which is blessed with the sincere cooperation of its visiting doctors. In this regard I believe that every hospital superintendent will echo the comment.

Operating Items Require Close Study

Practically, we have to do with established institutions, where capital investments, overhead and equipment are fixed and whose traditions in service and methods can not easily be changed. Here the problem of reducing costs is almost entirely an administrative one and, in order to attain results, close vigilance with constant study of operating items is necessary.

The problems before the superintendent cover the many details of hospital management, in fact, all parts of his daily routine. These may be summarized under the general items of careful cost accounting, efficient organization, elimination of waste, careful buying and an appreciation that more reduction can be made in the budget by economic use of supplies than by the closest buying.

High Cost of Nursing

One of the biggest items of expense in the cost of hospital care in the institution and in the charge to the patient is that of nursing. The schools of nursing education in California are now subject to state laws which govern the qualifications of the candidate, the amount of instruction to be given, the number of hours of duty required of the pupil nurse, and the requisite housing accommodations. While these regulations have greatly increased the cost of educating nurses, and consequently have added much to the charge of the patient, however no one desires to return to the former condition in order to reduce expenses. Present standards must prevail and if changes must occur they will move in the direction of

greater improvements. Although the state has imposed laws which entail heavy expenses upon the schools of nursing, no provision has been made for meeting this expense. Consequently the burden of it is added to the hospital budget and is reflected in the patient's bill.

Hospitals as Educational Institutions

On analysis it would appear, from one point of view at least, that the state is taking advantage of the educational possibilities of hospitals to procure without cost and for the benefit of the community at large, a body of well-trained, well-educated young women, who, in addition to being skilled nurses with definite help to offer, become better and more useful citizens because they are self supporting, impressed with the dignity of service, and possess a strong character developed by the invaluable experiences afforded by hospital work.

Is not the hospital, conducting the school of nursing without profit to itself, under state regulation and therefore along the distinctly educational lines, entitled to recognition and even support as an educational activity? I see very little prospect of reducing the cost of institutional nursing unless the nurse is recognized as a public asset and the cost of her education met either by the nurse herself or by outside contributions.

Cost of Special Nursing

As for special nursing, the present cost has attracted more attention than any other item of hospital expense. A charge of nearly $100 a week for special nursing is an appalling rate for a man of moderate means. Yet this is a common occurrence in cases of serious illness when a night and day nurse mean much in the safety and comfort of the patient. Relatives, under these circumstances, feel impelled to provide every facility which standardized nursing affords for the beloved sick ones, though the expense thereof may entail financial embarrassment.

The hospital often has no alternative to offer in such an emergency and yet on the score of community service, the institution should stand ready to advise and to provide an organized plan by which adequate nursing service may be rendered at a price which is within the patient's means. This has been met by some enterprising hospitals by the device of organized groups of graduate nurses who care for several patients through a division of hours. This system gives more care than that permitted by the hours of a ward nurse, and yet costs less than private duty nursing.

After all, however, the hospital rates for the rich and poor must be distributed in accordance with cost of service and accommodations used. If any rates are fixed for the benefit of those who are unable to pay the full cost, then the resultant deficit must be met in some other way.

Ways of Meeting Deficits

There are three ways of meeting deficits. (1) The rates for full-pay patients may be placed so high as to leave enough surplus to cover the deficit. This was formerly the regular method, but under modern conditions it cannot be done. Often regular charges cannot be made high enough to meet the deficits. Again there is an element of social injustice in attempting to tax anyone without his consent to meet expenses incurred by another. Full-pay patients should be charged a reasonable sum based directly upon the service and accommodations used, plus a reasonable percentage of profit.

(2) The deficit may be met by endowments. This has been the mainstay of hospitals in the past and has enabled them to offer accommodations to all classes at prices within the means of the patient. Endowments are becoming rare, however, and former endowments are proving inadequate.

(3) Finally, reasonable hospital deficits incurred in the interest of patients who are not able to pay the full cost may and should become a matter of community interest. On economic grounds alone all that class of patients known as part-pay patients should receive help. Every day of sickness of a worker is a financial loss to the community. To protect our present social organization and to prevent the augmentation of irresponsible classes, all who are temporarily embarrassed, or who are bound by family ties, who are the main support of dependents and who are willing and anxious to meet their responsibilities must receive every encouragement and assistance in preserving self respect in their endeavor to achieve economic independence. At least they should be granted hospital rates within their means.

It follows then that the general hospital which is the agency by which low rates are furnished has a definite claim on the community for financial reimbursement. This may take the form of municipal aid, contributions or endowments. But wherever a municipality is fortunate enough to possess a community chest, as is the case in this community, there lies the solution to the problem.

Science is the systematic classification of experience.—Lewes.

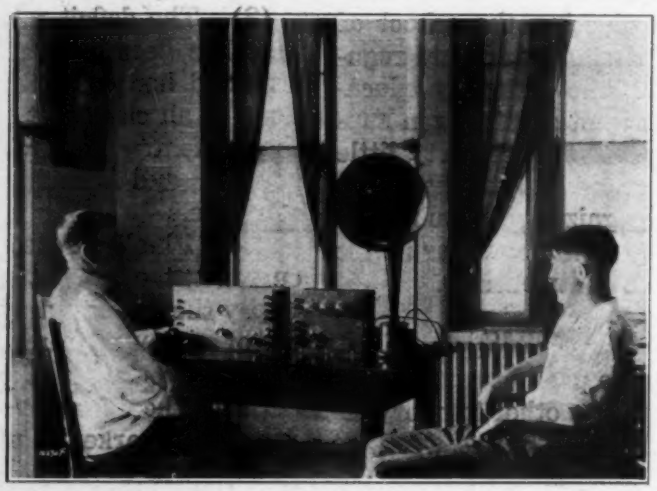
HOW RADIO BRINGS CHEER TO HOSPITAL PATIENTS*

By JUNE MOLL, New York, N. Y.

PATIENTS confined in hospitals and other institutions are the ones who really appreciate this unassuming instrument which brings to them the great outside world otherwise barred. Many of these institutions have installed the radio as a part of their regular equipment.

Take an invoice of the city of Pittsburgh, for instance. The three city tuberculosis hospitals located there are completely equipped; the Presbyterian Hospital has a very fine set installed in its chapel; and Saint Elizabeth's Hospital includes a complete equipment in its industrial ward. Besides these outstanding installations, there are numerous ones owned by private institutions and by individuals in other public wards.

The radio did not slip into these hospitals. In more than one case. it was tried out under protest before it won its permanent homes. When radio installation was suggested to officials of the tuberculosis hospitals, they cried "Never!" It would be a nuisance to nervous or extremely ill patients. Other institutions had tried radio without success, usually because no regular operator was assigned and indisposition prevented the patients from doing it themselves, or part of the equipment was broken through mistreatment by amateurs. Such were the theoretical objections proposed.



Radio set installed in employees' club room, Letchworth Village for Feeble-Minded, near Thiells, N. Y. A physician of the institution is operating and one of the employees is listening in.

"I think we would have a riot on our hands if we tried to take out the radio now," said a physician, formerly one of the most ardent objectors, when approached on the subject the other day. "It is indispensable and we have found that it operates satisfactorily."

Pittsburgh Hospitals Well Supplied

Two of the tuberculosis hospitals have single receiving sets permanently installed in basement rooms with wires leading to all parts of the building. Each patient is supplied with a headset so that any number may listen in without disturbing others. Power amplifiers also are installed in the basements and each hospital owns a loud speaking receiver which is portable. Upon occasion it is arranged to furnish programs of special interest to an entire ward or wing of the building. Church services are carried into chapel on Sunday, incidental music is supplied for bi-weekly picture shows, part of the instruction in classrooms is carried by the system to pupils, and once in a while entertainment for an "evening at home" is brought in to the nurses and attendants.

A member of the hospital board gave the radio to the Presbyterian Hospital with the provision that it be installed in the chapel. The set itself is one of the finest and it is picturesquely located but the provision has proved to be unwise. During only a few hours each week can suitable services be brought into the chapel and the equipment is not placed centrally enough for the patients to develop the interest necessary to operate it to much advantage.

The Carnegie Steel Company ordered a radio set installed in the industrial ward of Saint Elizabeth's Hospital. Most of the patients are convalescent from industrial accidents and are anxious to keep in touch with affairs outside the hospital and to have diverting entertainment. The set is located in a sunroom at the end of the ward and can be closed off whenever a patient in that section is too ill or nervous to listen. Because of this elimination of the "annoyance" element and another reason, the Saint Elizabeth installation is one of the most successful in the country.

The hospital keeps on its staff an electrician who makes all adjustments needed on the apparatus. The set consists of a standard receiving set, a power amplifier and loud speaker. All of it is enclosed in a glass-front case so that only the bell of the horn projects at the top, but a switch outside the cabinet allows the patients to turn the apparatus on or off. Occasionally one of the patients is put in charge of the tuning dials for the evening and feels his responsibility so deeply that he is more than careful. Reports have it that the

*The material and illustrations for the above article were furnished by the courtesy of the Western Electric Company, New York, N. Y.

set works a good eight hours a day and never even shows signs of fatigue.

1500 Patients Listen In

Besides furnishing the entertainment on nightly programs at the Red Cross hut of the Marine Hospital in Pittsburgh, the radio brings music for the frequent "hops." This apparatus includes receiving set and loud speaker. It is estimated that 1,500 hospital patients listen in on every program broadcasted in "the Workshop of the World." Their keen appreciation is voiced to directors of station WCAE. The studio executives say that a program is never broadcasted that messages of commendation and requests for special numbers do not come from at least one hospital in the city. Pittsburgh is only typical. Installations like that at Robert Parker Hospital, Sayre, Pa., and at the Henry Ford Hospital in Detroit are too numerous to include.

Radio set installed in the industrial ward of St. Elizabeth's Hospital, Pittsburgh. The men here, convalescent from industrial accidents, appreciate deeply this means of contact with affairs of busy folks outside and the broadcasted entertainment programs.

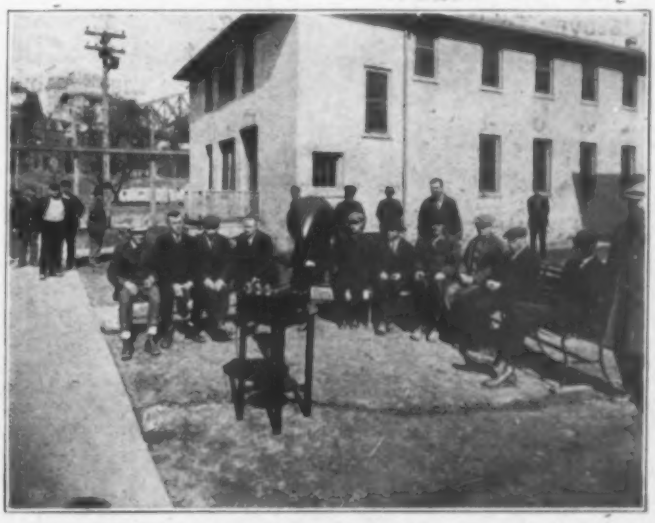
One of the most interesting installations near New York is at the Letchworth Village for the Feeble-minded, near Thiells. The village is in the country, forty miles away from New York City, and its residents are practically isolated from activities of the population beyond. The set is installed in the employees' club room and is used principally to provide entertainment for the employees of the institution. Of the 2,000 patients in the colony, a good many can appreciate radio programs and the majority enjoy music so that the instrument serves a double purpose. Each Saturday afternoon the horn is turned through the open window and a crowd of inhabitants gather on the lawn outside to hear the program. L. M. Bonneaud, superintendent, and his assistant, Mr. Stout, recommend radio.

People outside are interested in many things at Ward's Island, New York, but the people on the island necessarily have their interests limited. Of the list open to them, they cry loudest for their radio. Last Christmas the auxiliary of Bill Brown Post No. 507 of the American Legion, presented a radio outfit to the Manhattan State Hospital situated on the island. There are 100 ex-service men in this hospital and they have never ceased expressing gratitude for the gift.

Informs and Entertains Patients

Every evening "the boys" gather around the loud speaker which is attached to the set and listen eagerly for news of the day and then relax for the musical entertainment. When J. Gwelyn Anwyll sang "Crying for Water" during the

The loud speaker is the right-hand assistant to the teacher in this country school conducted in conjunction with a tuberculosis hospital. Radio contributes to the early battle against the germs which have been found in these children.



Ward's Island, New York. Convalescent patients from the Manhattan State Hospital, situated on the island, gather 'round the loud speaker to hear the news of the day, sporting results and musical programs.

veterans' night program broadcasted not so long ago by station WEAF, his buddies out at Ward's Island gave special attention. These same buddies formed the intensest of audiences waiting for returns from the Willard-Johnson and Firpo-McAuliffe bouts and then later for the big Dempsey fight. A bronze plate presented with the radio outfit says "in gratitude to our disabled ex-service men in the Manhattan State Hospital." The gratitude undoubtedly is a boomerang in this case.

From a study of these and other hospital installations, the following specifications may be laid down:

Install only a high-grade set. No real saving is made by using a cheap or home-made outfit, when the enjoyment of good programs is considered.

Place the set where it cannot be tampered with, in a locked room or cabinet, and allow only responsible people to operate it. Provide a switch outside so that it can be turned on and off at will.

Provide high grade headsets for the wards so that individual patients can listen without disturbing others. It is a simple matter to wire up the wards with outlets near each bed, into which a plug can be inserted.

Provide loud speakers for the sun parlors, club rooms and chapel so that groups may listen.

Unless someone on the house staff is a radio fan, insist that the dealer who sells the apparatus shall take the responsibility for installing and keeping it in order at a proper fee. Radio equipment requires attention—not much, but regularly, and by an expert.

Modern hospitals and kindred institutions throughout the United States are fast discovering the utility of radio. And as they adopt it, they discover further that it is the greatest of assets in attaining that state of mind on the part of the patients which the very best of such institutions strive for—the illusion of being quite outside institutional jurisdiction.

METHODIST HOSPITAL ASSOCIATION TO CONVENE FEBRUARY 14-15

The sixth annual meeting of the National Methodist Hospitals and Homes Association will be held February 14 and 15, in the auditorium of the Methodist Book Concern, Chicago, Ill. The following program has been arranged:

Thursday Morning, February 14

C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio, will preside.

10:00 Devotions, conducted by W. G. Wedderspoon, D.D., pastor, St. James Church, Chicago, Ill.

10:15 Presentation of minutes.

10:25 Announcements and appointment of committees.

10:30 "To What Extent do the Homes for Aged Meet the Demands of the Church and the Aged?" by Miss M. Clark, superintendent, Methodist Memorial Home, Warren, Ind.

10:50 Discussion.

11:00 "The Place of Girls' and Men's Homes of the Methodist Episcopal Church," by Miss Emma Linderud, superintendent, Norwegian-Danish Deaconess Home, Chicago, Ill.

11:20 Discussion.

11:30 "The Development of the Work of the Board of Hospitals and Homes," by N. E. Davis, D.D., corresponding secretary, Board of Hospitals and Homes, Chicago, Ill.

Thursday Afternoon, February 14

2:00 Devotions, led by C. H. McCrea, D.D., assistant editor, *Northwestern Christian Advocate.*

2:15 "National Methodist Tuberculosis Sanatorium," by the Rev. Karl P. Meister, field secretary, Colorado Springs, Colo.

2:40 "The Church and the Golden Cross," by the Rev. C. C. Jarrell, corresponding secretary, board of hospitals, Methodist Episcopal Church, South Atlanta, Georgia.

3:00 Group meetings: (1) Hospital group—Led by G. T. Notson, D.D., superintendent, Methodist Hospital, Sioux City, Ia. (2) Homes for the Aged—led by C. L. Stretcher, D.D., superintendent, Methodist Home for the Aged, Cincinnati, Ohio. (3) Homes for Children—led by S. W. Robinson, D.D., executive secretary, Methodist Home for Children, Williamsville, N. Y.

Thursday Evening, February 14

7:30 Devotions, conducted by the Rev. J. L. Anderson, financial secretary, Wesley Memorial Hospital, Chicago, Ill.

8:00 Lecture, "The House of Life" (with slides) by Dr. N. E. Davis, corresponding secretary, Board of Hospitals and Homes, Chicago, Ill.

8:45 Lecture, "Standardization of Hospitals," (with slides) by Dr. Malcolm T. MacEachern, president, American Hospital Association, Chicago, Ill.

Friday Morning, February 15

9:30 Devotions, conducted by the Rev. H. H. Parish, executive secretary, Wesley Hospital, Madena, Minn.

9:45 "The Status of Hospitals and Homes in Church Legislation," by J. A. Dickmann, D.D., president Bethesda Hospital, Cincinnati, Ohio.

10:15 Discussion.

10:30 Business session.

Friday Afternoon, February 15

1:30 Devotions, led by J. S. Harkness, D.D., executive secretary, Methodist State Hospital, Mitchell, S. Dak.

1:45 "The Field Man," by W. H. Jordan, D.D., executive secretary, Asbury Hospital, Minneapolis, Minn.

2:00 Discussion, by G. A. Reeder, D.D., superintendent, Methodist Homes for the Aged, Elyria, Ohio.

2:15 "The Educational Work of Children's Homes," by the Rev. W. L. Hestwood, Cunningham Children's Home, Urbana, Ill.

2:45 Round Table, conducted by Miss Mable Woods, superintendent, Methodist State Hospital, Mitchell, S. D.

HUNCHES AND HOSPITAL COSTS*

By JOHN C. DINSMORE, Ph.D., Purchasing Agent, The University of Chicago, Chicago, Ill.

Hunches are sometimes of value in predicting business conditions, but they are quite unreliable when not backed by scientific facts. They are not safe when they are relied upon in lieu of accurate investigation as to hospital costs. Many hospitals are unable to effect certain economies of purchase because the head of a department is deceived by his hunch as to what is causing the trouble. Upon investigation, such cases generally show that the hunch is a poor substitute for accurate cost accounting. Hospitals, generally, are slow to realize the necessity of detailed investigation in their attempts to reduce purchasing costs. In many hospitals a careful check-up has proved valuable.

MANY buyers for hospitals and other institutions place great dependence upon business hunches. They have a hunch that bedding will be higher, and they lay in a generous supply. They have a hunch that coal will be cheaper, and refuse to contract. They have hunches about every business transaction at one time or another. These hunch buyers are rarely able to give a concrete definition of a hunch, but apparently they consider a hunch as the masculine equivalent of a woman's intuition. The very danger of acting upon hunches lies in one's inability to define the term accurately.

Once you have begun to ask yourself "What is a hunch?" you immediately adopt a critical attitude. From this critical attitude to the conscious attempt to analyze the hunch and find what lies behind it, is a short step. A hunch which has been analyzed is no longer a hunch, but a business judgment based upon carefully marshalled facts and accurate data.

What Constitutes a Hunch

A hunch may, therefore, safely be described as a feeling that a certain action should or should not be taken, without being able to recite the facts which lead up to that decision. When you begin to line up the facts upon which the hunch was based, not only do you move forward from a hunch to a business judgment, but frequently you will decide to act contrary to the original hunch.

This point may be illustrated by the following concrete example. The superintendent of one of the great hospitals in an eastern city found that the dining room costs in the nurses' home were mounting and that there was an increasing number of complaints from the nurses. The steward, who was complacent and too easily satisfied, was replaced by another at a higher salary, and the situation improved temporarily.

After they moved into their new quarters, however, costs mounted again, and the new steward was called upon to explain. He said that he "had a hunch that the overhead charges were too high." It seemed to the superintendent that his hunch was perhaps based upon the fact that the steward's salary was somewhat higher than that of his predecessor, and he therefore proceeded to analyze dining room costs with the steward in order to develop the hunch into a business judgment.

He first asked what the overhead charge amounted to per meal, and the steward did not know. He next asked for a statement of what the other cost figures should be, and again the steward did not know. In other words, the steward ran the business "by ear" and not "by note." Instead of having accurate data concerning detailed costs in his own dining room, as compared to costs in similar institutions, he had nothing but a general impression—a hunch. Each day this hunch was costing the institution more than the steward's salary.

In this particular hospital the steward was allowed an average of sixty-six cents per meal served; in the last month his cost had been sixty-nine and nine tenths cents per meal and he had a hunch that the loss was the result of a too high overhead charge. By dividing the total overhead cost by the number of meals served the superintendent discovered that the total overhead charge was two and one-half cents per meal. Since the net loss was three and nine-tenths cents per meal, it was evident that the hunch did not have a sound basis. An analysis of the facts upon which the hunch was supposed to rest showed that there was no real foundation.

The superintendent was not content to let the matter rest there, however. He wanted to know how much it cost to cook a meal, and how much it cost to put it on the table. By dividing the total kitchen service and dining room service cost by the number of meals served he found that it cost eight cents to cook a meal, and five cents to

*This is the first of a series of five articles on hospital buying by Mr. Dinsmore, purchasing agent, The University of Chicago, Chicago, Ill.

put it on the table. The only other cost item was the raw food cost per meal, which amounted to fifty-three and nine-tenths cents. A comparison of these cost figures with those in similar institutions developed the fact that the overhead, kitchen service, and dining room service charges were all low, but that the raw food cost should have been about thirty-five cents per meal instead of fifty-three and nine-tenths cents per meal.

Reducing Costs By Investigaion

In other words, his costs were as shown in the first column, and should have been about as shown in the second column.

Item	Actual cost per meal	Normal cost per meal in similar institutions
Overhead	2.5	2.5
Kitchen service	8	8
Dining room	5	5
Raw food	53.9	*35.
Total cost	69.4	50.5
Income per meal	66	66
Deficit	3.4	Profit 15.5

*Approximately.

Once these figures had been secured, it was quite evident that the only item that needed further investigation was the raw food cost, which was nearly nineteen cents per meal too high. This too high cost must be due to some one or more of the following factors:

(1) Lax buying, resulting in too high unit prices.

(2) Buying unsuitable grades and qualities, such as using fancy canned goods for making pies and the like.

(3) Waste in the kitchen.

(4) Theft or graft.

The superintendent learned that the steward, without shopping, placed most of his orders with a single firm. By judicious shopping the unit price on standard goods was somewhat reduced. A careful check-up showed that a better arrangement of the menu would make it possible to serve better food at a lower unit cost. We all like the thought of buying strawberries in January, but they are more palatable in June, and much cheaper.

Kitchen wastes were checked up and corrected, and that left just one other possible source of loss, that of theft. After the superintendent had found the chef trying to take home a hundred pound bag of sugar, he replaced both the chef and the store keeper; and the costs began to go down.

The steward's allowance per meal is still sixty-six cents, but instead of showing a loss of $300 per month, he is now showing a profit of over $400.

The steward's hunch had no foundation upon fact. An impartial attempt to locate the basis of the hunch lead to an analysis of the factors involved. This analysis of the situation produced the material for a comparison of unit costs with similar data from other institutions, and this in turn turned a loss of $300 a month into a profit of over $400 a month. This hunch, like most hunches, had no firm basis and so proved expensive. Few hospital superintendents or stewards can afford hunches. Following hunches in business is like sleep walking on a high roof. If you survive you're a wonder; if you walk off the roof, the results are just as unpleasant as if you had deliberately planned to commit suicide.

Whether your dining room costs are or are not reasonable largely depends upon the amount of accurate daily cost data your system provides. Using hunches as a substitute for business judgments based upon accurate data is a luxury few hospitals can afford.

MISSISSIPPI INSANE HOSPITAL OPENS SOLDIERS' PAVILION

The new soldiers' pavilion of East Mississippi Insane Hospital, Meridian, Miss., for the care and treatment of soldiers affected with nervous and mental diseases has recently been opened. The building was erected and equipped by the State of Mississippi at a cost of about $100,000.

View of new soldiers' pavilion, Meridian, Mississippi.

It accommodates about sixty patients, and is fire-proof in every particular. It contains amusement rooms, library, day room, sleeping quarters, its own dining room and kitchen and quarters for occupational therapy. Steel sash springs without any iron bars are used and the windows are so constructed that they cannot be opened wide enough to permit anyone to slip out, but at the same time, adequate ventilation is provided.

A large athletic field, and swimming pool have been provided. There is also a school of occupational therapy where the men who are mentally fit learn to make lockers, wardrobes, and other furnishings.

THE COUNTY HOSPITAL IN IOWA

By AMY BEERS, Superintendent, Jefferson County Hospital, Fairfield, Iowa.

The county hospital idea, as worked out in Iowa, is destined to become a working health center in rural communities of this country. As Miss Beers outlines, the county hospital can embrace the large scope of services which these districts need and should have. The organization of such a hospital calls for a director trained in hospital administration who possesses a broad vision of public health work. The success of such a health center also depends upon the cooperation of members of the medical profession and upon the efficient working of the out-patient and social service departments. The county hospital should also be allied with the educational centers of the community.

TWELVE years ago Iowa began an experiment which was destined to become of world-wide interest and which has been emulated by a number of other states. Dr. E. E. Munger of Spencer, Iowa, a man of broad vision, imbued with the spirit of service, believed that the people of the rural communities as well as the people of the larger towns and cities should have the advantages afforded by a well-equipped hospital. A bill was passed making it possible for every county in Iowa to build and maintain a hospital by taxation. Washington County was the first to take advantage of this beneficent legislation and her neighbor, Jefferson County, soon followed, there being but two months' difference in the opening of the hospitals in the two counties.

In a decade the "Iowa idea" of a community hospital has been "sold" to thousands of people, and it is now generally believed that these institutions are a necessary part of the equipment of modern civilization of any rural community. "How did we ever manage without the hospital?" is heard frequently and not infrequently from people who voted against its establishment.

Human life can not be valued rightfully in dollars and cents, but the legally estimated cash value of the lives saved in one year in one county hospital far outweighs the total expense of the hospital's maintenance. The hospital pays the biggest dividends of any of our public institutions.

Service Capacities of the County Hospital

At this time, it might be well to briefly review the ways in which the county hospital serves the community: (1) It has saved many lives; (2) it has lessened the sufferings of many of our people; (3) it has taught many people how to prevent illness; (4) it has helped many babies to make the right start in life; (5) it has lessened the dangers of maternity; (6) it has been an educational factor in the community and has minimized the spread of the communicable diseases; (7) it has increased the efficiency of the doctors of the county; (8) it has been a home for the homeless sick; (9) it has sent out from the school of nursing young women qualified to be useful members of society; (10) it has developed a new community consciousness of our common responsibilities for human life.

Any one who has staid with the county hospital since its inception is fully alive to the educational force it is in the community but is also alive to the still greater power it might be in the community if all possible avenues for broader activities were to be developed.

Why should not every county use its hospital as the unit of a health center and not confine its operations to the care of sick people? Why wait until people come to the hospital for help? Too often we are saddened by the admission of a patient who has waited too long for care or who, through ignorance, has failed to recognize the early symptoms of a serious condition.

The County Hospital—A Health Center

I am confident that it is possible for the counties that are maintaining county hospitals to develop a real health center by having the board of trustees of the hospital ask the county for the full maintenance tax of two mills, and class the activities outside of the hospital walls as hospital extension work.

There should be a director who would be responsible to the board for everything connected with the center. It is preferable to have as director an executive who is trained in hospital administration and who has a broad vision of public health work with actual knowledge of the purpose of the center. A well qualified director of this type, providing she possessed good judgment and a fair amount of tact, will not be hampered by any lack of co-operation of, or a misunderstanding by, members of the medical profession. The success of a county health center depends largely upon the degree of enthusiasm aroused in the doctors of the county and, because of human jealousy, it is advisable to place all on an equal status.

In order to have such a health center function smoothly, the director should have capable, well qualified, interested assistants in each department

to carry out the detailed plans, and it is most essential that each assistant be thoroughly conversant not only with the plans for her particular phase of the activities but with the whole plan of work so that she may visualize her place in the general scheme. Frequent and regular staff conferences tend to co-ordinate the various workers.

As a beginning, in order to build for the permanence of the center, the activities may be confined to just a few of the fields crying for attention. Have a real active out-patient department and let not one single opportunity for health education slip by. Teach the people to keep well-worn the path to that out-patient department. Establish a social service department. Follow up the patient after he leaves the hospital and prove a real interest in his welfare.

Have at least two *good* public health nurses in field work in the county. Their opportunities are unlimited—pre-natal instruction, the care of the pre-school child, the inspections of the school child, and special guidance for the adolescent are just a few examples. They can arrange for and assist at clinics, dental, tuberculosis, orthopedic, infant feeding, maternity, etc. It is alarming to note the number of infants who die before reaching the age of six weeks. Talks on hygiene and prevention of disease must be given to clubs, parent-teachers' associations and neighborhood groups—in fact, advantage must be taken of every chance to reach the ears and eyes of the people. Examination of the water supply, the care of milk, the disposal of garbage and excreta are but a few of the important subjects these "apostles of health" may use. Only by persistent reiteration and forcible illustrations of the laws of health will we drive home to the general public the good to be derived from the observance of the same.

Many public health nurses have learned that through the stimulation of the interest of the school child, the parent is most often reached. Classes in home nursing and hygiene should be conducted for the high school girls. In this connection, it is gratifying to mention that the Des Moines schools are giving such courses. Affiliations can be arranged with the college of the community and with the state university so that the educational facilities may be increased. These affiliations may be both for theoretical and practical instruction.

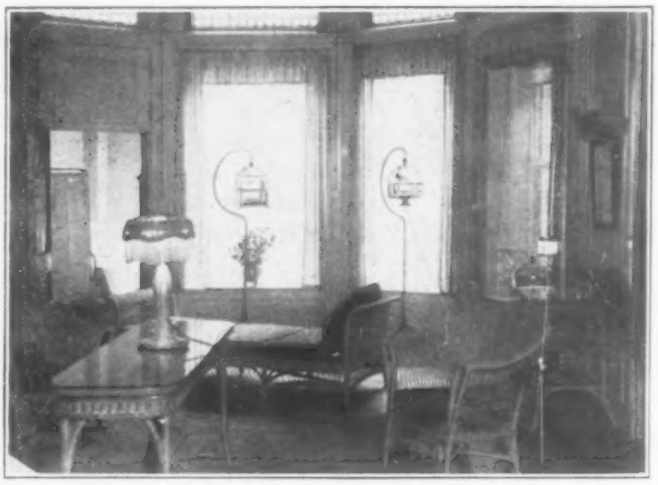
Well-equipped, functioning, clinical laboratories are a very important requisite in this scheme and *must* not be overlooked. You are not playing fair with the patient if this service is not provided.

With all of the legislation favorable to promoting health, why should we who choose to live "where the tall corn grows" spare any effort to provide clinics for instruction and visiting nurses for relief in addition to hospital care for our citizens?

From this mental picture of a real county health center in a rural community I can see in the future, when the plan is successfully worked out, a race of well developed people so healthy that no longer will figures tell us the city is a safer place than the country in which to spend our days.

THEATRICAL REST ROOM OPENS

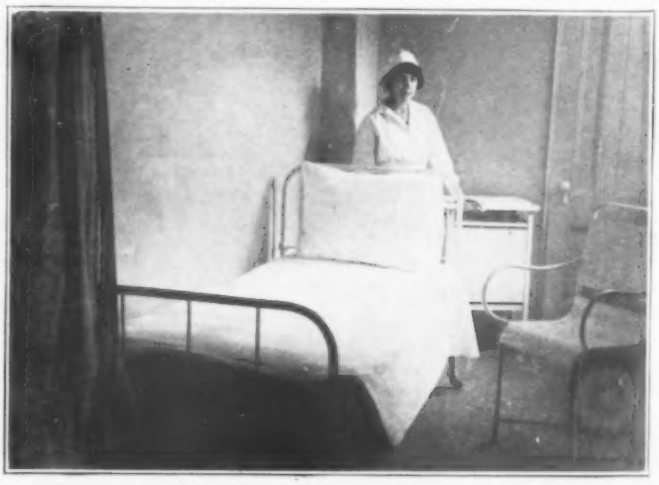
One of the unique features of the New York Theatrical Rest Room and Emergency Room, 64 West 47th Street, which was formally opened November 4, is the emergency room which is fitted up in hospital fashion. The room is in charge of Miss Elsie Speer, a trained nurse, and is



Ladies' waiting room of the New York Theatrical Rest Room showing emergency room in the background.

equipped with white enameled bed and first aid equipment. A number of well-known physicians have volunteered their services for emergency calls, and sudden calls sent in from any theater will be promptly answered. The service is free to all in the profession, and the room will be open daily from 11:30 a. m. to midnight.

The rest room is the outgrowth of the abandonment of plans for the proposed New York Theatrical Hospital.



View of emergency room, New York Theatrical Rest Room.

TOLEDO HOSPITAL HAS WELL EQUIPPED PATHOLOGICAL LABORATORY

By THEODORE ZBINDEN, M.D., Toledo Hospital, Toledo, Ohio.

THE installation of a modern laboratory requires much planning based upon the actual experience of the trained worker. Just as in the present day industrial plant, in the clinical laboratory every detail that adds to the worker's efficiency should receive attention.

It is best to divide the laboratory into four or five separate rooms or compartments and equip each for a special line of work, such as routine urinalysis, tissue room, serological department, blood chemistry, sterilizers, incubators, record room, etc. The rooms or compartments should be as small as possible without undue crowding. The work bench should be of such width that all parts are in easy reach. Shelves and drawers should be liberally supplied and conveniently arranged so that all equipment and material are readily accessible. Numerous sinks, hot and cold water faucets, gas and electric connections, should all be conveniently placed.

Exterior, Toledo Hospital, Toledo, Ohio.

Our table tops are almost entirely of poplar or white pine to which we have given the dressing, according to Stitt's directions. We find these much more economical and serviceable than either plate glass, cement composition, or any enamel. Plate glass is sure to crack sooner or later and must be replaced at considerable expense, in addition to which the hard surface increases the breakage of glassware.

Each worker has her own microscope and accessories. We are using, exclusively, artificial illumination for microscopes, as daylight varies too much. The sub-stage lamps with bulbs are a perfect substitute, giving a constant light and requiring no mirror which calls for continual adjustment.

The pathological laboratory of Toledo Hospital has been allotted a liberal amount of space on the fourth floor of one wing. Altogether it occupies about 800 square feet and, as it gets daylight on three sides, is a pleasant work shop with plenty of light and ventilation.

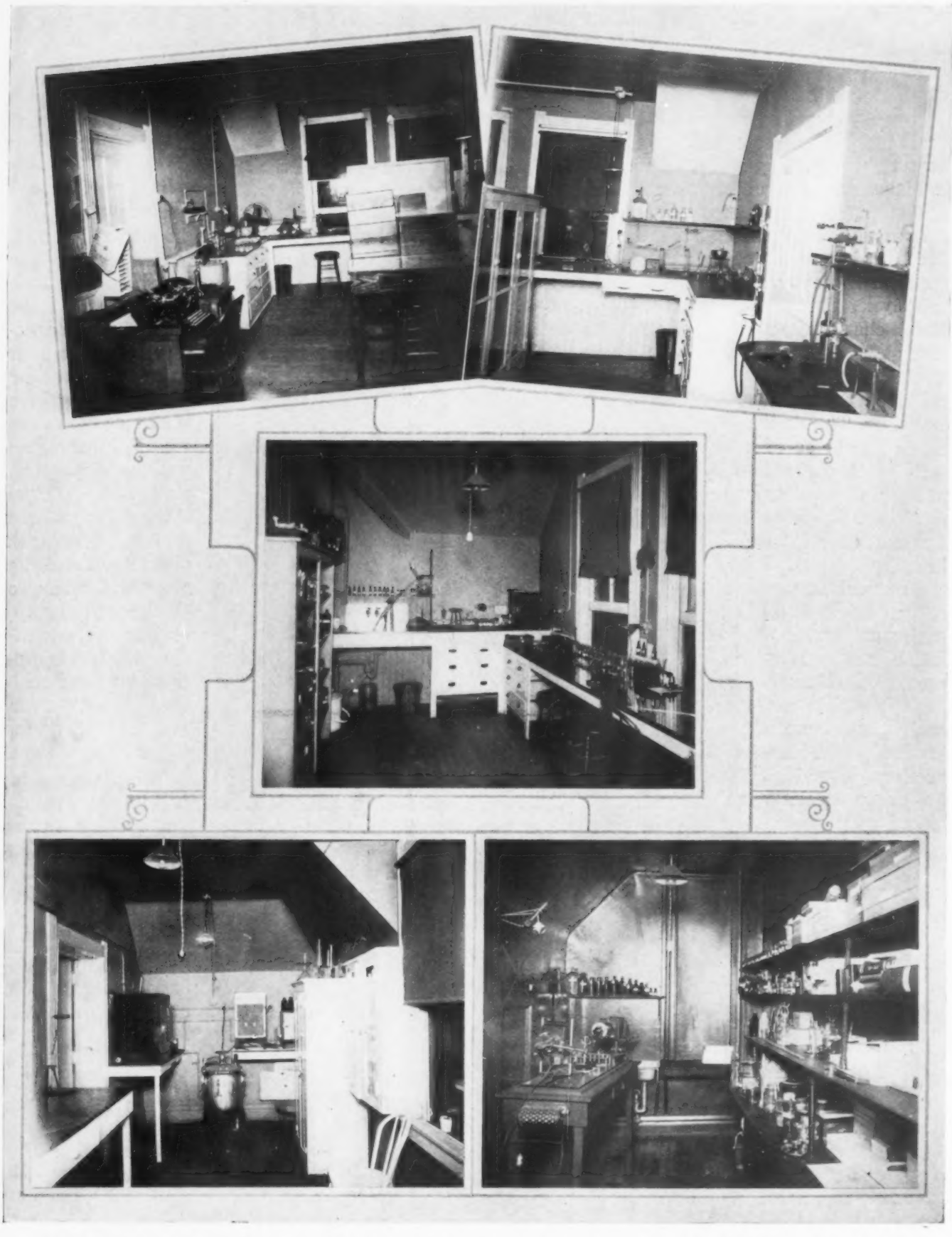
General Work Room

The general plan is shown in figure 1, p. 123. One enters the large general work room on the east side of which an incomplete partition has been built to form separate compartments for blood chemistry and serology. To the right is the tissue room with a large closet serving as the dark room. Another large room at the south end not so well lighted serves well for incubators, sterilizers, lockers; it also has a hood and a space with sink for washing glassware, etc. To the left is the pathologist's private office, which also contains the filing cabinets, book cases, and a cabinet for museum specimens.

The tissue room is nine by twelve feet and has a work table thirty inches high by twenty-two inches wide, set against the two windows. This table has a plate glass cover and holds microscope, microtome, staining dishes and bottles, and reagents. Numerous drawers are at the one end where there is also a higher work bench holding the paraffine oven in one corner, and the sink at the other. Over the sink is a high shelf for large siphon bottles with distilled water, formalin solution, Zenker's fluid, and Kaiserling's solutions. A cabinet with shelves is on the inner wall, where specimens are arranged and kept until sorted. Another corner of the room has a high bench forty inches high for frozen section work. Here are the frozen section microtomes connected with the CO_2 tank, all necessary implements and reagents. A reserve tank of the gas is always kept in a corner near by.

Figure 3, p. 123, gives the floor plan of this

VIEWS OF INTEREST IN THE TOLEDO HOSPITAL LABORATORY



(Upper left) Tissue room; (upper right) general work room—serology; (center) general work room—blood chemistry; (lower left) corner showing placement of incubators, sterilizers and other equipment; (lower right) dark room, for photomicrographic work.

One of the laboratory offices, Toledo Hospital.

room and together with the picture will be self-explanatory. The six foot incomplete partition was for obvious reasons more practical here than the making of two or three distinct rooms. It is much less expensive and at the same time serves the purpose of forming separate working rooms and furnishing wall space for shelves and cabinets. Our suction machine is a very small one directly attached to a 1/16 horse power motor. It connects with a small pipe having half a dozen outlets, with stopcocks, so that almost any number of aeration outfits can be used simultaneously.

On the hospital grounds there is a shed for the guinea-pigs, rabbits, and the sheep. We prefer to keep a sheep for bleeding purposes. A year-old male weighing 125 to 150 pounds has been found very satisfactory. It is easy to get blood from the jugular veins until they have been badly

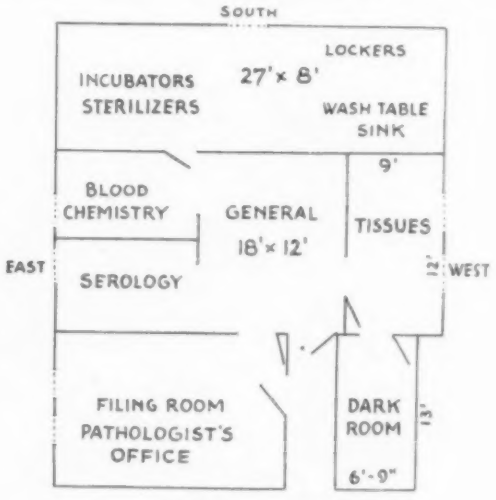


Fig. 1. General plan.

damaged by repeated punctures. About once a year we dispose of the old sheep and purchase a new one.

Another important part of the laboratory is the large autopsy room which is located in the basement. It is completely equipped as a separate unit.

The laboratory force at present consists of the pathologist, who is on half time, four trained technicians, and a maid. We have found that by far the best plan is to employ well-trained technicians at liberal salaries. Our laboratory women are all college graduates who have planned their courses for this occupation. They are thus enabled to carry out the most complicated work with accuracy and speed, and the laboratory reports are accepted without question by the medical staff.

Fig. 2. Tissue room.

Directions for the ebony-like finish on tables.

In using it the surface of the wood must be new (free of any varnish, oil or paint. If previously coated, the surface must be planed.

Solution No. 1.

Ferrous sulphate	20 gm.
Cupric sulphate	20 gm.
Potassium permanganate	40 gm.
Water, q.s.	500 cc.

Apply two coats of this solution at least twelve hours between applications. When thoroughly dry apply two coats of solution No. 2.

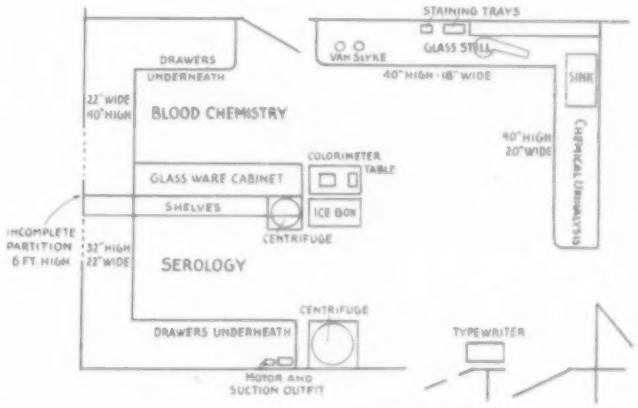


Fig. 3. Floor plan, general work room.

Solution No. 2.

Aniline oil	60 cc.
Hydrochloric acid	90 cc.
Water, q.s.	500cc.

When this has dried apply a coat of raw linseed oil with a cloth. After this is dry wash with very hot soapsuds.

Continue rubbing with a dry cloth until no more black comes off.

INSIDE PUBLICITY*

By RALPH WELLES KEELER, Counsellor in Publicity of the Board of Hospitals and Homes, Methodist Episcopal Church, New York, N. Y.

BEFORE some of the special phases and types of publicity are discussed it is important that the matter of publicity for and among the staffs, employees, and trustees of the hospital be considered. Many of the larger and more picturesque items needed for publicity for the public at large will come from these groups, once they are awakened to the fact that they are the ones who are doing the things concerning which the public desires to be informed.

Anyone who is acquainted with the inside of the hospital knows that most hospitals are behind other establishments in the organization of personnel. The employees of many hospitals never know anything about the institution other than what takes place in their particular department. This situation is serious, as far as hospital publicity is concerned, for it makes coordination between departments very difficult. Other establishments which employ a large number of people have for some time realized the advantage of having a house organ or similar publication. Lately a few hospitals have begun to publish monthly news sheets to promote cooperation among employees.

Moreover, and quite as important, if not more so, is the need of having everyone connected with the institution conversant with all that the hospital is doing. Those who guard the entrance ought to know what happens to a patient once he is entered on the office records. The nurse should have some knowledge of how the foodstuffs and medicine which she requisitions from day to day, are purchased, cared for and prepared for her use. The elevator man would take a keener interest in his task if he heard more about the hospital than "Second floor, please," or "Let me out for the operating room." And the folks who wash and iron in the laundry might even get an inspiration from their task could they know a little of the uses made of the results of their labors.

When an individual knows what's going on in other departments than his own, and feels that he has a right to know, his attitude toward the institution undergoes a change. He is lifted out of the rut into which routine work on the same task every day has driven him. He becomes a part of the whole process. If he be the fireman, he not only shovels coal into his furnaces, but when he goes home at night he tells his family "We had a wonderful operation at *our* hospital." And he gives them the information which has been prepared for his benefit, and not some garbled story of "some funny business those doctors pulled off the other afternoon." For gossip slips around the corridors of the hospital as well as it does in other institutions. One of the best antidotes and preventatives for back-stairs gossip in a hospital is giving every one connected with the institution the exact facts, in terms that the least equipped mentally may understand.

A general knowledge on the part of everyone connected with the hospital helps to wipe out the cast system that sometimes exists. It is natural for the professional group—the physicians, surgeons and specialists—to feel that they are a little better and more important. Nurses are apt to be haughty toward charwomen. Administrative officers always question—at least in their own mind—whether the professional staff is as important, or any more so, than they themselves. And trustees are inclined at times to manifest an altogether unfortunate aristocratic overlordship attitude which tends to alienate employees.

That "Inside Publicity" is necessary and that it makes for better morale has been discovered in every institution that has tried it. Nay, those that have tried it would not go back to the old way of having from fifty to a hundred and fifty people working on a part of a task and only a very few of them knowing what all the others are contributing to the total results.

The Hospital News

In a high-line lumber camp back on a mountain in the state of Washington I was accosted by a man with a wooden leg who gave me considerable information concerning the folks employed in the camp. That evening while at supper with the men in the bunkhouse "dining room," I repeated some of my information. Upon being asked the source of my news I spoke of meeting this peripatetic dispenser of news and was informed with laughter that he was "The Camp Tribune."

Even back on the mountain the husky fellers of trees want the news. And because there is no paper, someone takes upon himself the task of supplying all the news needed. The hospital

*This is the ninth of a series of articles on hospital publicity prepared for The Modern Hospital by Mr. Keeler.

should issue at least monthly "The Hospital News," of course selecting such a name for it as appeals locally. It need not be printed. The rotospeed has demonstrated how such a publication may be issued without much bother and at a trifling expense. Run off on the rotospeed on paper eight and one-half by eleven inches, which can be assembled and fastened together, the pages may carry not only the articles and facts desired but also illustrations to liven it up. And the illustrations do not involve the expense of cuts, as they are drawn into the stencil, just as the letters are typed in. This method of providing limited numbers of "home-grown" newspapers is having great vogue throughout the country and awaits the use of hospital executives.

What Constitutes News

The monthly appearance of "The Hospital News" means that nearly everyone will give a careful reading to its pages. The new boilers just put in, their size and cost, the length of time taken in installing them, will be read with interest. The new method used for keeping dust down will receive varied comment. How the superintendent knows the quality of the new blankets just purchased for the hospital will be discussed at the supper table and compared with knowledge on that subject already possessed. The plans for a new building will be a cause for rejoicing. Everyone will have a common knowledge of this sort of news. And when folks begin to have knowledge in common with others they begin to feel more closely related to the other person's task.

A message from the superintendent should appear in each issue. In it he has opportunity for discussing those things that have to do with improvement of morale. He may discuss the favorable comments made on attention given and service done. He may give consideration to criticisms of the hospital and its employees that arise from time to time, shaping his message, however, so as to treat the criticism under discussion in a constructive manner. Matters that an executive desires all those under him to have the same information about may be worked into such a message. There is practically no end to the possibilities for strengthening morale in the part of "The Hospital News" used in this manner by the superintendent.

A page description of the function and work of each department, featuring one a month, gives an excellent medium for supplying information which gives every one a clear understanding of how one department's work is necessary to the success of all the others. In the course of months a good working knowledge of what the hospital does and how it is done is the common property of all.

There should always be news items from each department. Some one can be selected as reporter in each department, in order that news items will be available when the paper is being made up. An unusually successful operation or some baffling case conquered make good reading. Some queer things revealed by the x-ray are of interest. The number of people treated answers many questions. Picturesque items out of the day's work of the telephone operator and the information clerk are useful. Some dry-as-dust statistics may be transformed into concrete illustrations, such as the number of square feet of floor that must be mopped daily in terms of the surface of the ground occupied on a nearby square; the number of wards and rooms the cows who furnish the milk, cream and butter for the hospital would occupy if driven into the institution; the number of dresses the hospital's sheets would make if worked up for that purpose; the length of a procession if the patients for a given period were marched past four abreast; the length of time per day that the total telephone calls of all employees use up. Once started on this line, there will always be suggestions for material to prepare for this section of the paper.

In addition, each department head could write a brief "How You All May Help Our Department," using a different department each month. Personal news items can be incorporated, as the publication circulates among the hospital family. And now and then some greeting from the trustees would be of value. "The Hospital News" can be made a most helpful instrument of service in many ways. It should be some one's definite task to see that it is a success.

Give Employees Printed Matter

In many institutions the finest kind of informative printed matter is allowed to remain on the shelves of closets and is finally thrown away. No one ever thinks of passing it around among the people who work in and make up the institution. Yet these same folks would read and profit by the reading of this literature.

It is wise to see to it that every employee is on the distribution list when a piece of literature comes from the press. By so doing, a particular booklet or leaflet becomes the talk of the hospital the day that it appears. It is taken home, read and discussed by the families of each employee. Some send their copy to friends in order that they may know something about the institution employing them.

This plan should include the annual report.

When a department leaflet appears, sufficient copies should be provided the department described to permit of its being mailed to as many people as those in the department wish to have it. The "Trip Through Mt. Sinai" should be given in numbers sufficient for children of employees to take a copy to their school teachers.

The putting into the hands of each employee from superintendent to orderly gives every one fresh, concrete and definite information at the same time. This is valuable for their background. It also makes everyone feel that he is an actual part of the institution and in this way he becomes a part of the process of strengthening the morale mentioned above. More than this, it stirs the publicity sense of some one every once in a while, with the result that new and unthought of stories of real interest are suggested.

In some hospitals the graduating nurses get out a year book. This is of the general character of a high school or college annual. It deals with the lighter side of life. It is joyous and at times hilarious. Jokes on staff and employees abound. The distribution of this annual among the hospital force at the expense of the hospital is a worth while investment. It is one more tie that binds the thought life of the institution more closely together.

Sight Seeing at Home

There are people who live in Philadelphia half a life time, who after they have moved to another city go back to visit the United States Mint. This is characteristic of most of us. And there are those employed in a hospital for years who have never seen any other part of the institution but the department in which they work. This ought not to be.

If employees know the task others are doing and have seen the surroundings in which they do their task, a deeper sympathy and understanding is developed. There is also a keener interest in the day's task when the chef sees the patients who eat what he prepares, when the information clerk is familiar with the inside of the wards, rooms and offices to which she directs people, when the ambulance driver sees how the folks he brings to the hospital door are taken care of, and when the telephone operator knows at least where the telephone receivers are located which she is continually "plugging in."

Therefore, a sightseeing tour of the hospital for the employees should be a part of the annual program of publicity for them. It should be done in as thorough and instructive a manner as the plan outlined in "Publicity Through Visitation." Manifestly, the entire force cannot be shown through the institution at once, but all of it can be done in a few days by taking small groups at a time. The results attained by this sightseeing at home will amaze the most optimistic.

The Annual Dinner

Most hospitals have an annual dinner to which are invited the trustees, the medical staff and prominent citizens. It is a stiff formal affair, arranged for by the hospital superintendent because "it must be done" and attended by the guests for much the same reason.

An annual dinner for the hospital family is quite a different affair. It is the occasion when the dietitian may joke with the chef and the physician forget his dignity and talk in plain English to the supervising nurse. Those who are married bring their wives. The program is arranged by a representative committee and has some of the "folks" as speakers or to participate in other ways. Songs are prepared for the occasion. Perhaps the hospital quartette—the ambulance driver, the butcher, the engineer and the new intern—add to the festive spirit by a number or two. It is the hour of relaxation from the necessary formal routine. Each one present gets a new and more normal conception of the others. And in such an atmosphere, the address delivered by the superintendent sinks in as seed sown on good ground.

The expense of the annual dinner is very small. The good spirit engendered and the lift given to the growth of the "actually belonging" feeling more than repays the financial outlay in a very short time.

While the trustees may not be classified as employees, they should be included in the plan for inside publicity. Only by so doing will there be developed in them a feeling of vital relationship to the institution whose affairs are entrusted to them. Meeting once a month to consider the working and needs of the hospital does not give them the close touch with the life of the institution which trustees ought to have.

For the most part, men and women elected to a hospital board of trustees are very busy people. It is usually because of their interest in large and engrossing affairs that they are selected as trustees. Because of this their minds are occupied daily with things that give them very little time for quiet constructive thinking about the hospital. They receive the agenda for the monthly meeting a day or two before it is called and often look it over hastily on the way to the meeting itself.

This state of affairs can be remedied by carefully thought out publicity for the trustees as such. It will involve some time and a little labor.

But to have trustees assembling for a monthly meeting alert with fresh knowledge of the hospital's affairs and a constantly growing interest in every item of its daily life is worth any amount of thought and labor.

Much of this type of cultivation must be correspondence. And the letters to trustees should not be form letters, nor should they be multigraphed. An agenda for an annual meeting recently received had as a footnote "Any member of the board unable to be present should send word to that effect immediately." Had not the agenda been read through as soon as received, it would not have been understood to be the only call to the meeting that would be received. And its general character would not act in any way to urge a busy man to make special effort to be present. Nor did the agenda of itself alone stress the unusual importance of this particular meeting. A personal letter accompanying the agenda, urging the presence of the particular individual and pointing out the problems he could be helpful in solving would be a factor in the decision he must make as to whether or not he would put the hospital board meeting above other demands that were pressing for his attention.

The same thing is true when a piece of literature comes from the press. The completion of the printing of the annual report gives occasion for a letter pointing out items of unusual interest, the number of copies printed, how they have been distributed and any changes as to character of the mailing list over other years. "A Trip Through Mount Sinai" affords the chance to call attention to the quality of the booklet, the purpose for which it was prepared, and the groups it is hoped to reach with it. The same opportunity arises with the appearance of each leaflet prepared and printed. Especially does the Nurses' Year Book lend itself to such discussion. And in each letter so written there is the further opportunity of stressing some item of importance which should be gotten into the mind of every trustee.

But it is not necessary to wait until some piece of literature is printed to write a letter of information to the trustees. Every week should bring something of real value to convey by way of a letter to every member of the board of trustees. They need to be cultivated as well as does the general public. Some of the suggestions for inside publicity for the hospital family would furnish a newsy paragraph. The trip through the hospital, some comments on the literature, a description of the annual dinner—there are many things about the hospital which trustees would enjoy hearing about. For the business meetings which they attend are largely confined to reports of a general character, pleas for new equipment and larger buildings and discussions of ways and means to meet existing or impending deficits.

It might be well occasionally to have the time of the monthly meeting of the board of trustees so arranged as to make possible a visit, on adjournment, to a ward, or a department, the operating room or the laundry. A half hour spent in the dispensary would be of exceeding interest. This method of visiting a section of the hospital at a time would be more valuable for the trustees than a complete tour at one time. It would give them opportunity to think through the problem of the part visited in a thorough-going manner before the next meeting. It would result in a new type of discussion at the next meeting, and possibly bring forth a few letters before that time.

The processes of dispensing information are many and varied. The hospital superintendent may feel that he is already burdened quite enough without trying anything beyond what he is now doing. But surely it is worth while, nay, absolutely necessary, that every person connected with the hospital have such a knowledge of the institution and its affairs that gives him a personal interest in what he and his fellow workers are doing. Otherwise the day's task too often becomes uninspired drudgery and he has no thought of the wonderful humanitarian ministry of the hospital or that he contributes to it in any way whatever.

The deeper the whole matter of publicity for hospitals is studied, the more it is seen that there is work enough in this field for the whole time of an experienced man or woman. And that board of trustees of a hospital shows great wisdom in providing a budget both for such a publicity expert and for the carrying out of plans that are developed for bringing the hospital to everyone in general in a human, interesting way.

A GUIDE TO THE PLANNING OF SMALL HOSPITALS

Problems relating to the construction and equipment of hospitals vary greatly with their size. The building and equipping of the small hospital have been generally found to involve problems of arrangement which only thorough knowledge and skill can solve. In answer to the demands for advice and suggestions in building and equipping the small hospital, THE MODERN HOSPITAL has published a book of "Prize Plans for a Small Hospital," a book which is devoted to the construction, equipment and organization of small hospitals, and contains a number of prize plans which were submitted in the prize architectural contest held by the magazine last year. The books are now available and may be purchased for $1.00 apiece.

NURSING AND NURSING EDUCATION IN STATE HOSPITALS

By ELISHA H. COHOON, M.D., Superintendent, Medfield State Hospital, Medfield, Mass.

THE importance of the problem of caring for the insane can be appreciated to some extent if we stop to realize that in this country there are at the present time approximately 210,000 persons suffering from mental diseases being treated in state and large county hospitals. This means that from a financial and economic standpoint as well as from a humanitarian and charitable standpoint the care of the mentally ill is the greatest of all state health problems. About 34,000 persons are employed in these various state hospitals and approximately fifty per cent or 17,000 employees are directly connected with the nursing part of the work.

That a certain amount of trained nursing is absolutely necessary in the treatment of the mentally ill is now generally recognized. The difficulty is in securing nurses who are adapted to psychopathic nursing and in giving them the training which this type of work requires. Training schools in state hospitals have generally stressed the care of the individual patient and have neglected the training of the pupil nurse along the lines of general medical nursing. On the other hand, the general hospital trained nurse is not at her best in a psychiatric hospital and is not generally interested in this field. More and better training schools are needed in mental hospitals to meet the demand in this field.

That the general welfare of the mentally ill has been neglected is a fact, the acknowledgment of which many of us regret. It is also strange, though true, that disease of the mind has always been the last disease to receive attention. Undoubtedly this has been due to several factors or causes, the most important of which I believe has been the failure of the public to look upon insanity as a disease. Although in recent years great strides have been made in the way of enlightenment and the understanding of mental disease, yet we find those about us who still apparently feel that the so-called mental disease is nothing more or less than a manifestation of some diabolical influence or action.

Indifference Toward Mental Disease

In the past the medical practitioner rather kept away from the subject. He took it for granted that nothing could be done for those thus afflicted and regretted that the whole problem was a hopeless and distressing one. He realized and acknowledged that those of us whose minds had been twisted or deviated had to be taken care of and he was content that the state should assume the function of shutting them up and properly housing and feeding them. The attitude of the medical profession may be summed up as one of indifference, hopelessness and helplessness. The general public was prone to look upon mental disease as somewhat of a disgrace and felt that when the insane person was placed in confinement and removed from a position where he might be embarrassing to his relatives and friends the matter was successfully and happily managed.

It is not necessary, and probably not fitting, to take up here the development of the care of the mentally sick. Generally, members of the medical profession as well as the public are aware that in the last few years there has been marked improvement in the care of the insane and a great advance made along lines of scientific treatment, but we of the medical profession who have been trained in psychiatry realize that this advance has not kept pace with the progress made in the study of disease of other organs. At present the psychiatrist is extremely hopeful that in the near future there will be a proper realization of the necessity of applying to the care of the insane the same degree of scientific interest and investigation that obtains in the treatment of any other disease.

Need for Trained Nurses Now Felt

Not many years ago it was like a voice crying in the wilderness for one to claim that the mentally ill actually required trained nursing. Those who were interested would agree that the mental cases that were bedridden should be taken care of by those who had some training in nursing, but could not understand why it was necessary for the ambulatory cases to require anything more than custodial care. However, the idea that the mentally sick require trained nursing has grown and developed to a point where it is generally accepted by those who are responsible for their care and it is now felt that a certain amount of trained nursing is absolutely essential if we are to expect results in the treatment of this class of cases.

About forty-two or forty-three years ago there were a few who believed that the way to obtain trained care for the mentally ill was to introduce a training school into the hospital taking care of this type of patient and thus a school was opened up at this time at a private hospital for the care of the insane. This worthy example, although applauded by some, was slow to be emulated by those in charge of the state hospitals. However, superintendents soon began to see the value of it and as the years passed more and more training schools were opened in state hospitals. At first the course of training was rather short and decidedly immature and incomprehensive. Considerable stress was laid on the proper attitude toward the individual patient's expression of mental symptoms and also on the importance of general health measures, such as proper feeding and bathing, but apparently insufficient attention was given to the training of the pupil nurse along the lines of general medical nursing.

Medical Training of Nurses Neglected

In many instances the psychiatric nurse was graduated without any general hospital training. After a time it was realized that a certain portion of the course should be spent in a general hospital where a knowledge of all other branches of nursing education could be obtained. It is to be regretted that this latter requirement has not been felt necessary in many of the training schools in state hospitals that are even now granting diplomas to their nurses. The number of training schools and those requiring affiliation with general hospitals gradually increased up to the advent of the late World War. This event interfered greatly with maintaining training schools in state hospitals during the period of the war and later was responsible for conditions that prevented a return of the training schools to their former positions.

It should be of interest to know, at this time, just exactly what the situation is in the whole United States in regard to the number of training schools and the success of their operation. With this in mind, in 1922 questionnaires asking for information relating to the existence or non-existence of a training school and other information as to the number of pupils, number of teachers, the character and extent of the courses, were sent to 156 state and large county hospitals devoted to the care and treatment of the insane. Of this number there were 109 replies. It was assumed that the forty-seven hospitals that did not reply had no training schools for nurses and this was substantiated by reading the reports of those particular hospitals. Fifty-four hospitals state they had training schools for nurses, this being about fifty per cent of those who replied to the questionnaires, and if we can assume that there were no training schools in those hospitals that did not reply it would mean that training schools for nurses are found in only thirty-five per cent of all state and large county hospitals.

Superintendents Favor Training Schools

The results of the questionnaire would indicate that we have not made very much advance in the establishment of training schools in state hospitals. Only thirty-eight of the fifty-four were giving a three years' course and the same number had affiliations with general hospitals. Using the same figures, we have a right to conclude that only in about twenty-five per cent of instances do we find that the state and large county hospitals are giving what appears to be an adequate course in nursing education. One might conclude from this that probably the superintendents of state hospitals were not in favor of a training school for nurses and did not believe in its value. However, it is interesting to know that of the 109 replying all with the exception of two expressed a very strong opinion in favor of the establishment and maintenance of a training school in the hospital. Those who had no schools deplored the fact and explained the situation on the basis of their inability to obtain pupil nurses with adequate qualifications. One hundred and seven of the 156 state that they consider a training school as an essential part of the equipment for taking care of the insane. Those who had schools told of the great difficulties in keeping them up to a standard both as to numbers and quality of personnel. One hundred and seven of the 109 expressed a wish that something might be done to remedy the condition.

General Hospital Training Inadequate

It is believed by some that the necessary trained nurses' work in a state hospital can best be supplied by the employment of a graduate from a general hospital. In a small psychiatric hospital I believe the needs of the patient can be very well met by such an arrangement but it is my experience and the experience of other superintendents of large state hospitals that the general hospital trained nurse is not at her best in a psychiatric hospital and will not compare for this particular kind of work with the nurse trained in the psychiatric training school. The general hospital trained nurse has not a primary interest in the work. For the first few months is of very little use, and in fact, rarely appears to get the true spirit of psychiatric nursing.

Another idea is that all general hospital nurses

should take a course of several months in a psychiatric hospital. While I believe this would be of some value to the nurse and incidentally to the general public I am not impressed that it would provide the necessary nursing in the state hospital. The affiliated nurse from a general hospital would be in the state hospital such a short time that her interest would be hardly aroused. Then, too, on account of the work being disagreeable to her, she might become a disturbing element among the attendants who are attempting to do most of the nursing work. Therefore, considering the above ideas, I believe we are justified in concluding that the adequate care of the mentally sick in the state hospitals is best arranged for by the establishment of a training school for nurses in mental hospitals.

Psychiatric Training for Health Work

But the demand of the state hospital for the psychiatric nurse is not the only justification for a psychiatric training school. Many cases of mental disease are taken care of outside the hospital. Year by year there is a better and greater appreciation of the field of psychiatry as it applies to the general community health. The development of the mental hygiene idea is already being felt. We know of many psychiatric clinics which are being opened throughout the country. In fact, I am convinced that soon there will be instituted a great mental hygiene program. The successful carrying out of the above will require the services of well trained psychiatric nurses and hence it seems almost imperative that steps should be taken to meet these requirements.

The question naturally follows, "What can be done to improve the general situation and what means can be taken that will lend to an increase in the number of psychiatric training schools?" This question involves a consideration of the particular type of school needed, its size, its curriculum, and everything connected with the successful operation of a training school. Let us first study the conditions of a training school in a state hospital and also attempt to discover why, as has already been shown, there is so great difficulty in operating one. The requirements of this type of a training school will naturally demand specialization along the lines of every day care of the insane patient. The pupil will have to be taught a sufficient amount of psychiatry to get some understanding of what she is attempting to do, and will also have to have a knowledge of hydrotherapy and occupational therapy. At the present time most state hospitals have quite a large number of patients confined to bed and many have surgical operating rooms. It seems essential then that this course shall provide not only theoretical but practical bedside teaching along the lines of ordinary clinical and surgical nursing.

Requisites for Psychiatric Training

The course, therefore, must necessarily include an affiliation with a general hospital teaching all the subjects that are ordinarily given in a general hospital. It would seem that the length of the course should be three years. In general the curriculum will have to be arranged to meet, primarily, the special needs of the hospital and, secondarily, to give an education in general nursing so as to fit the graduate for all types of nursing. I do not believe that the training school should be of an inferior type or standing but necessarily should be able to meet the standards set by the board of registration in nursing in the state to which the particular hospital belongs.

Probably the time will never arrive when all those engaged in the care of the insane can be in a training school and I do not believe that it is necessary. Much of the work in caring for an insane patient is laborious and does not require specialized training. I do not believe that it is necessary that the training school should consist of more than one-half of the personnel of those taking care of the patients on the wards. The value of a training school does not depend so much upon its graduates or the number of those taking the course as it does upon the fact that there is a training school in the hospital, even though its members are relatively few. The training school will provide in the whole number of those connected with the ward service a definite group of those who can be taught the best things and the highest ideals and whose work can be made to approximate a high standard of nursing care. I believe this setting of a standard will affect the work of those not in the training school, resulting in the whole care being raised to a higher level.

Obstacles to Training Schools

Let us now consider the difficulties in getting pupil nurses and in maintaining a school. Many causes operate against establishing and maintaining a psychiatric training school. They may be summarized briefly as follows:

(1) The feeling of aversion of the general public toward any association with the mentally sick; (2) the nature of the ward work, it must be admitted, is more or less disagreeable and hard; (3) the long hours; (4) general living and dietary conditions; (5) the fact that hospitals have not interested themselves in maintaining psychiatric training schools of the standards set

by the best general hospital training schools.

I am not one who believes that good things can generally be obtained without paying a corresponding price. If the hospital requires a training school it will have to pay for it. The pupil nurse must not be overworked, she must live under as good conditions as the general hospital nurse and be treated in every way as a pupil nurse in a general hospital training school is treated.

The state hospital is usually so limited in regard to expenditures that it does not feel that it can arrange for shorter hours, for better food, for better rooms, and for more and better teachers. I believe that when state hospitals can offer a pupil nurse the same conditions that a general hospital can offer, in addition to the salary usually paid, it will not have great difficulty in getting pupil nurses with suitable educational and other requirements. It will provide the bright young woman, who has to be self-sustaining, an opportunity to obtain a good nursing education. The establishment of a training school, however, cannot include all those on the ward service so that in the state hospital it will probably always be necessary to have a certain proportion, usually a large proportion, of attendants. A short course of about twenty lectures and demonstrations should be given the attendants. This will supplement the work of the training school. The above arrangement is the system in vogue in the Massachusetts state hospitals where, in most instances, it works out very satisfactorily.

What Standardization May Accomplish

In an effort to stimulate the development of psychiatric training schools throughout the whole United States and Canada a movement was started in 1922 to standardize them. The question was brought officially before the American Psychiatric Association for its support and assistance in working out a standardization scheme. It was recommended that the association maintain a standing committee to be designated as "The Committee on Psychiatric Training Schools for Nurses"; that this committee make a survey of the psychiatric training schools; that a standard of training schools for nurses be established by the committee, subject to the approval of the association; that the committee shall list and classify all training schools approved by the association and also shall include a list of schools recommended by the committee for approval; that the report of the committee to the association shall be published annually in the *American Journal of Psychiatry* together with a list of the schools approved by the association; that certificates be issued by the association to approved schools. Last year this association practically adopted the above recommendations and they will be put into effect this coming year.

I believe that we may look for the following results: (1) Increase in the number of psychiatric training schools; (2) elevation of the position of the psychiatric nurse; (3) improvement in the nursing and medical care of the mentally ill.

DR. WILLIAMS REELECTED DIRECTOR OF MENTAL HYGIENE COMMITTEE

Dr. Frankwood E. Williams was reelected medical director of the National Committee for Mental Hygiene at the annual meeting of the board of directors, held in New York City, December 28, 1923. The following were elected members of the executive committee: Dr. William L. Russell, medical director, Bloomingdale Hospital, White Plains, N. Y.; Dr. Walter E. Fernald, superintendent, Massachusetts School for the Feebleminded, Waverley; Dr. Stephen P. Duggan, director, Institute of International Education, New York City; Dr. William A. White, superintendent, St. Elizabeth's Hospital, Washington, D. C.; Dr. Charles P. Emerson, dean of the medical school, University of Indiana, Indianapolis; Dr. C. Floyd Haviland, chairman, State Hospital Commission, Albany, N. Y.; Dr. Arthur H. Ruggles, superintendent, Butler Hospital, Providence, Rhode Island, and Mr. Matthew C. Fleming, attorney, New York City. Dr. William H. Welch, president of the National Committee for Mental Hygiene, presided.

Hospice de la Salpétrière, Paris. Our readers will find reference to this hospital on page 27 of the January, 1924, issue.

MORRISTOWN PROVES VALUE OF COMMUNITY CHEST TO HOSPITALS IN SMALL CITIES

By FRED H. LAWTON, Executive Director, Morris Community Chest, Morristown, N. J.

Morristown, N. J., is a striking example of the successful operation of a community chest in a small city. The adoption of this method of financing the hospitals of that community came as the direct result of increasing deficits. Although the community chest has been operating but a short time it has displaced the old hazardous methods of financing and has eliminated the successive individual appeals which prove a source of irritation to the public. It has resulted in educating people to the superiority of federated financing by gaining their confidence, and is developing a goodwill toward community enterprises. What Morristown is doing may be accomplished by other small cities.

MORRISTOWN, N. J., a city of 17,500 inhabitants including its immediate surroundings, is nationally famous as the headquarters of George Washington and the Revolutionary army during the winter of 1779. Almost as well known is the fact that it is a prosperous and beautiful suburb of New York, within the thirty mile limit, and the home of many wealthy people. Not as well known, but a matter of local pride, is the ten dollars per capita contribution which it has made during each of the last two years to its local charitable institutions, including two hospitals, one a general hospital and the other a Roman Catholic institution. This contribution is made through the medium of the Morris Community Chest (Morris from Morris County) which was organized in 1922.

Deficits Overcome by Community Chest

The adoption of the community chest method was the direct result of the rapidly increasing deficits of the two hospitals under former methods of financing. For the three years preceding 1923 the deficits of the hospitals were increasing at a rate of about $20,000 a year on account of increasing demands on their services without a corresponding increase in revenue. This situation was fast becoming so serious that it was felt that some new method of money-raising must be tried or the hospital services would necessarily have to be curtailed.

Morristown has now had two community chest campaigns, one in October, 1922 to raise money for the calendar (budget) year 1923 and one last October for the year 1924. The total budget to be raised for the 1923 expenses of sixteen organizations was $155,374, of which amount $89,287, or fifty-seven per cent was for the expenses of the two hospitals. The total amount subscribed for 1923 was $173,469 which allowed $9,500 to be applied to community chest administration and campaign expense and a balance of $8,595 for a contingent fund. Shrinkage in subscriptions through non-collection in 1923 approximated two and one-half per cent of the total amount subscribed, but this shrinkage was off set in part by $1,200 received from interest on bank deposits and investments. The 1923 campaign for 1924 budget expenses shows to date an even better result.

With this brief summary of the financial success of the community chest method in Morristown, some comparisons should be made with previous methods of raising money. It will be noted that the cost of raising money through the community chest, including all administration and campaign expenses, is five and two-fifths per cent of the total. This compares with money raising expenses of the sixteen organizations previous to the federated plan of from five per cent to fifty per cent of their budgets.

Old Financing Methods Hazardous

An outstanding and perhaps extreme example of the old methods is one of an institution which held a concert for its benefit at which a world famous violinist appeared. The concert was a great success—as a concert—but the fee of the violinist was $1,000, and when the advertising and other incidental expenses were added and the balance struck the amount turned over to the institution was infinitesimal. Only good luck prevented "realizing a deficit" for the institution.

Fairs and bazaars are notoriously uneconomical ways of raising money and yet these and other indirect methods such as bridge parties, balls and entertainments were formerly the principle means used to secure support from the general public for the two hospitals. In these indirect appeals the hospitals were competing with fourteen or fifteen other organizations which were using the same methods in appealing to the same people. Hardly a day passed in the business district in which business men were not "held up" to

buy tickets or advertise in programs.

But this is far from telling the whole story. None of these institutions could meet its budget requirements by indirect methods. Every month, sometimes twice a month, organizations would conduct "whirlwind" campaigns of personal solicitation. If these failed to reach their goal, as they often did, mail campaigns would follow.

The psychological effect of this continual solicitation on every hand, particularly on business men and the wealthier inhabitants, was what might naturally be expected—a feeling of annoyance and irritation at the *successive* appeals which made it difficult to judge any appeal on its merits.

This feeling has now entirely disappeared. Once a year each organization submits its budget requirements for the following year to a budget committee composed of men who have the confidence of the community. Careful comparisons are made with the itemized expenses of previous years and any new or extraordinary requests are investigated. The needs of each organization in relation to all of the others and the ability of the community to respond to their appeals is taken into account. Possible economies are suggested and encouraged. The final authorized budget is therefore accepted by the community as one that is fair and just to all concerned and is practically a guarantee against waste and extravagance.

Only One Campaign a Year

One campaign lasting one week covering the whole community is then conducted and in every way it is made clear that there will be no other appeal for the current expenses of any of the federated organizations, either directly or indirectly, for one year. Subscriptions are taken which can be paid quarterly during the budget year. One appeal therefore obviates one hundred direct and indirect appeals. Simplicity and system have taken the place of confusion and inadequate financing. Executives and boards of directors are entirely free from financial worries. Their whole time and thought can be devoted to the actual work of the organization. The "pay check" which comes like clock-work once a month is sufficient to supply all budget requirements and pay all bills promptly. No more do harrassed executives call emergency meetings of the directors to decide how outstanding bills are to be met—with the usual decision to borrow more from the bank and trust to Providence.

One of the most important functions and results of federated financing is the education of the general public in regard to its institutions. In the first year of the Morris Community Chest the number of direct subscribers to the hospitals and other institutions increased from 800 to 6,400, a seven hundred per cent increase. Every one of these subscribers, new and old, has received attractive information about the service rendered by the institutions. Knowledge has supplanted ignorance and active good-will has taken the place of indifference. New and valuable workers have been brought into the campaigns and the campaigns themselves are full of enthusiasm.

There are always some citizens who have a particular interest in some charity, a hospital for instance, and who wish to continue to give their support to such charities. Provision is made in such cases for designated subscriptions which shall be apportioned to these organizations first. This system, which is used in practically all community chests, takes care of the psychology of the giver, but where the total budget is raised it obviously has no further practical value as in such case all budget requirements are met.

The designation system is only one of many items of community chest technique which should be studied by any community which contemplates adopting this method of financing its charitable institutions. This technique differs from and supplements the technique of money-raising campaigns which developed during the war, and it is advisable for any community to obtain expert advice before and during its first campaign.

The best source of information is the National Information Bureau, 1 Madison Square, New York City, which acts as secretary for the American Association for Community Organization, although most of the information compiled by this association is more applicable to large communities than to small. The principles of success are, however, the same everywhere and may be summed up in careful preparation, proper personnel and adequate publicity.

DR. SAVAGE TO MAKE WORLD-WIDE STUDY OF HOSPITALIZATION

Dr. A. J. Barker Savage, Broad Street Hospital, New York, N. Y., has resigned his position as superintendent to devote his time to a worldwide study of hospitalization and group medicine. Dr. Savage sailed on the U. S. Voltaire, December 15, for Europe where he will begin his six months' study. Upon his return, Dr. Savage is expected to assume the presidency of a medical college and teaching hospital. He founded and built the Broad Street Hospital six years ago and under his direction the institution has grown from a fifteen bed emergency hospital to a 185 bed general hospital. He also incorporated many of his ideas of group medicine in this hospital.

How good is man's life the mere living; how fit to employ
All the heart and the soul and the senses forever in joy.
—Browning.

PSYCHOPATHIC BUILDING OF THE GALLINGER MUNICIPAL HOSPITAL, WASHINGTON, D. C.*

By SAMUEL W. HAMILTON, M.D., Director, Division of Hospital Service, National Committee for Mental Hygiene, New York, N. Y.

FEW chapters of modern hospital development are more interesting than that of the psychopathic hospital. Such an institution, according to the best use of the term, is a relatively small one wherein an attack can be made on any sort of mental problem. The mentally sick are received for examination and care until transferred to larger hospitals for mental diseases, if the treatment is expected to last a considerable period. To the out-patient department are sent children from schools and children's societies. These children may be mentally defective or they may be problems in management, resulting from another cause. Many of them are fundamentally quite normal but through misfortune of their own or someone else's making, they have met situations which are so difficult that conduct is affected. All sorts of social reconstruction agencies refer to the psychopathic hospital many cases for examination and advice. The courts welcome this opportunity to secure careful examination and unbiased expert opinion on many of the delinquents brought before them. In fact, in the more progressive cities, the psychopathic hospital or psychopathic ward of the general hospital has become an essential part of all the welfare and corrective mechanisms of the city. Instruction is given to students of medicine, nursing, social service, occupational therapy, law and psychology.

Too often when the observation ward for mental cases has been an outgrowth of the prison or lockup it is but little better than its parent institution. We find that many cities which used to be content with such an arrangement are now making plans for new hospital construction in order that such problems may be given proper attention.

The Gallinger Municipal Hospital in the District of Columbia has erected and occupied a new building during 1923. It is known as the psychopathic branch or Gallinger Psychopathic Hospital. It is a very attractive brick building, colonial in style; the architecture is simple yet distinctly classic in character. Approaching, one sees the west elevation, and the front gradually discloses itself, with agreeably proportioned arches through which vehicles may pass toward the rear of the building. Graceful columns flank the front entrance. From such a pleasant approach, a patient or visitor may well obtain a favorable impression of the place to which the mentally ill are coming for early and intensive treatment.

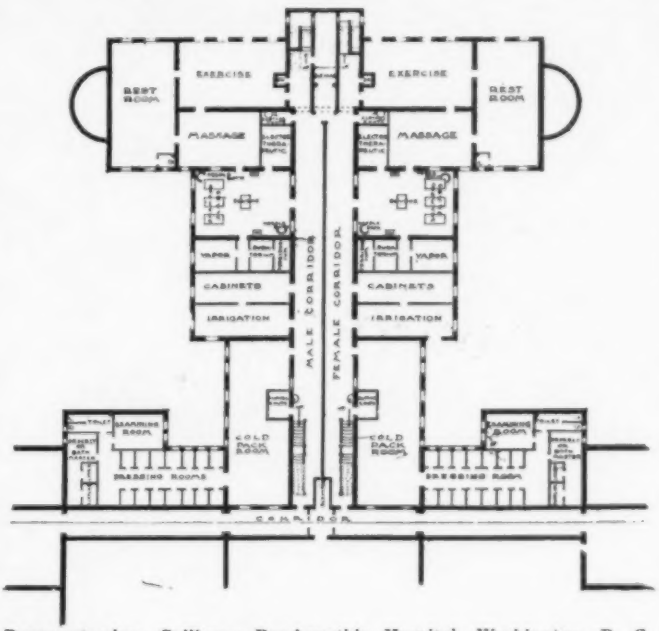
Let us remark in passing that too often money has been wasted in order to make a building a monument to the committee, the commissioners, or whoever it is that has the handling of the funds. Only too often is a pleasant effect obtained at an inordinate cost—or the inordinate cost is expended without obtaining even a pleasant effect. This building makes no such impression, for both outline and materials are modest.

View of hospital showing main entrance on left with west wing on the right, connected by corridors below ground. A driveway at the street level and an open passageway on the second story are also shown.

The building may be described as a front center section, two wings and another center section at the rear. The entrance for patients and visitors

*This is the third of the series of articles on State Hospital Construction prepared by Dr. Hamilton. The writer is grateful to Dr. D. Percy Hickling for courtesies connected with this study, and to Mr. T. B. Kidner for aid and counsel.

is not at the center of the front. The doors here lead directly into a lecture room, with a roomy platform and seats for 150. The central and convenient location of this lecture hall emphasizes the teaching functon of the hospital since medical and nursing students, students of social service and all others who can be benefited by clinical demonstration of mental cases are thus provided with a comfortable room in which to attend lectures. This arrangement eliminates the confusion of tramping through corridors in order to reach the lecture hall, a matter which has not always received sufficient thought. In the rear of this lecture room is a commodious center hallway which is reached by most visitors through a side door, stairs and elevator in the middle leading to the basement and second story. Around the margins of this hall are various rooms in which the administrative offices are located. There are also four visiting rooms, since in Washington it is necessary to provide for white and colored persons separately as well as to divide the sexes.



Basement plan, Gallinger Psychopathic Hospital, Washington, D. C.

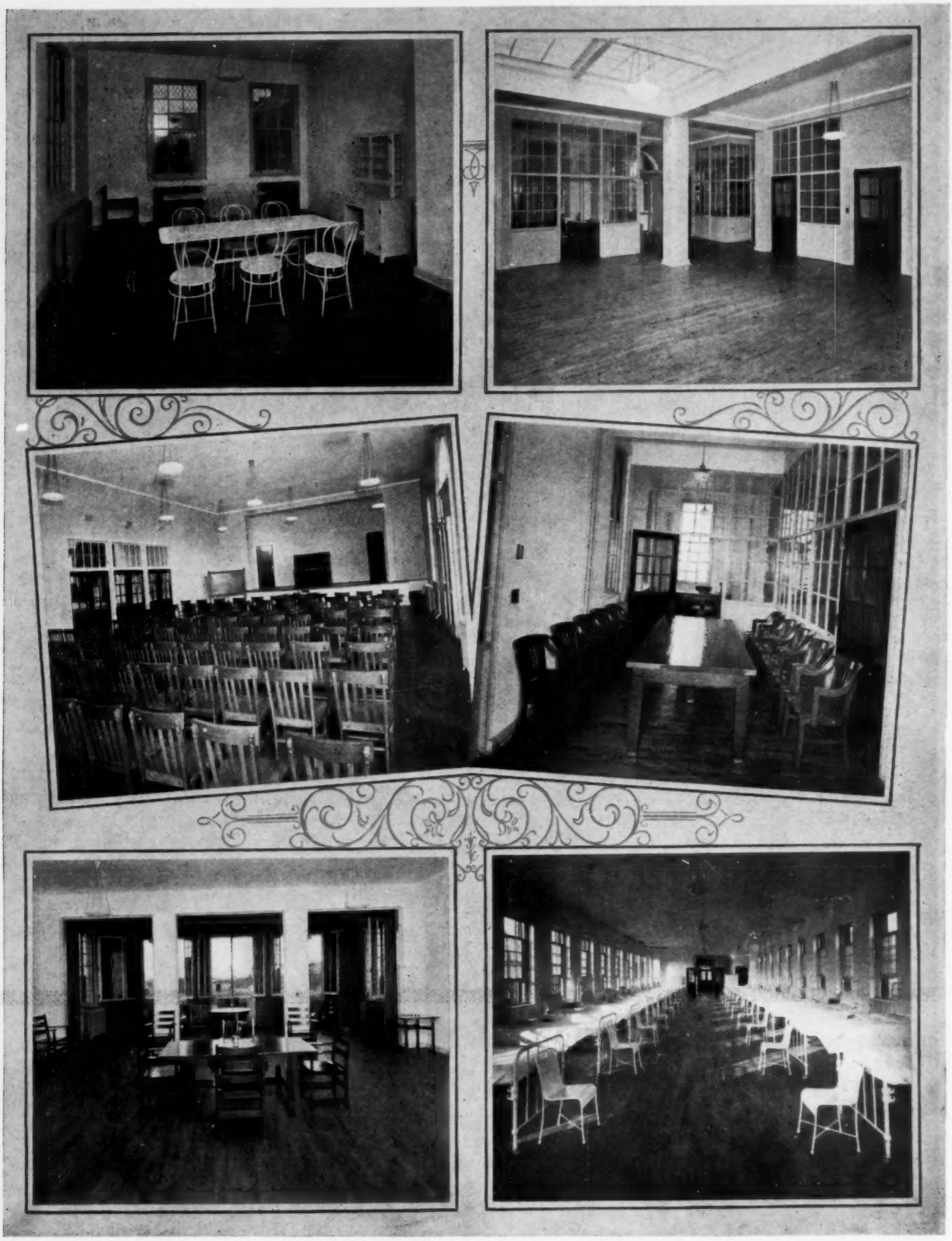
Near the entrance hall for visitors there is a long information desk from which may be seen almost everything that goes on in the center of the building. To the rear are two examining suites consisting of examining room, bedroom, toilet, bath and closet. Between the counter and these suites is a short hallway opening on the ambulance driveway. Thus patients may be brought in at any time without their coming in immediate contact with visitors. The medical and nursing offices are across the building from the counter at which inquiries are made. The general effect of this center section is distinctly good and may be expected to impress favorably both visitors and patients. Particularly commendable is the arrangement by which the patients come in contact as little as possible with visitors. If this is carried a step farther the separation will be complete and patients can be brought in, examined and taken to their wards without attracting notice from anyone except the officials and clerks responsible for obtaining information and making proper entries. Temporarily the examining rooms quarter interns and new patients are received in the rear building.

The wings are homologous, each being an irregular cross. The men are placed in the east wing and women in the west.

As one walks from the office across the ambulance driveway under cover of the second story roof garden, he sees toward the rear of the building a pleasant prospect of neatly cemented walks and drives, with a central section which will be adorned with beds of colorful flowers. Ascending a few steps one enters the front corridor of the wing. This corridor is ten feet wide, and opening to the front are three bedrooms, a dining and serving room, nurse's toilet and the day room. Two of the single rooms have a joint entry and may be used for a patient and private nurse. A parallel corridor five feet nine inches wide extends from the internal end of the wing almost to the cross-arm, separated effectually from the main corridor by a wall which has only two doors.

Off this secondary corridor are five bedrooms designated for boisterous patients, a room with toilet and washstand, and another room with a tub for the prolonged bath, and a bed. All these rooms have cement floors and the bedrooms have special sound-resistant walls. In three of them a special guard has been put over the radiator. It is a heavy sheet of iron perforated by many small holes and extends completely across the end of the room under the window. It is not unpleasant in appearance and should be quite effective, but the whole thing must be removed in order to clean under the radiator, a difficult job and probably one not attempted very often. The wire mesh used to protect the windows in these rooms has apertures that are too large, and will probably have to be replaced. In the doors to the single rooms are ingeniously designed peekholes so that a very small aperture leads into a rapidly flaring metal cone. The result is that the examiner's eye is not apt to be visible to the person inside of the room, though the observer has a very good view of the whole interior. If one wishes a peekhole, this arrangement is a decided improvement on the

INTERIOR VIEWS OF GALLINGER PSYCHOPATHIC HOSPITAL



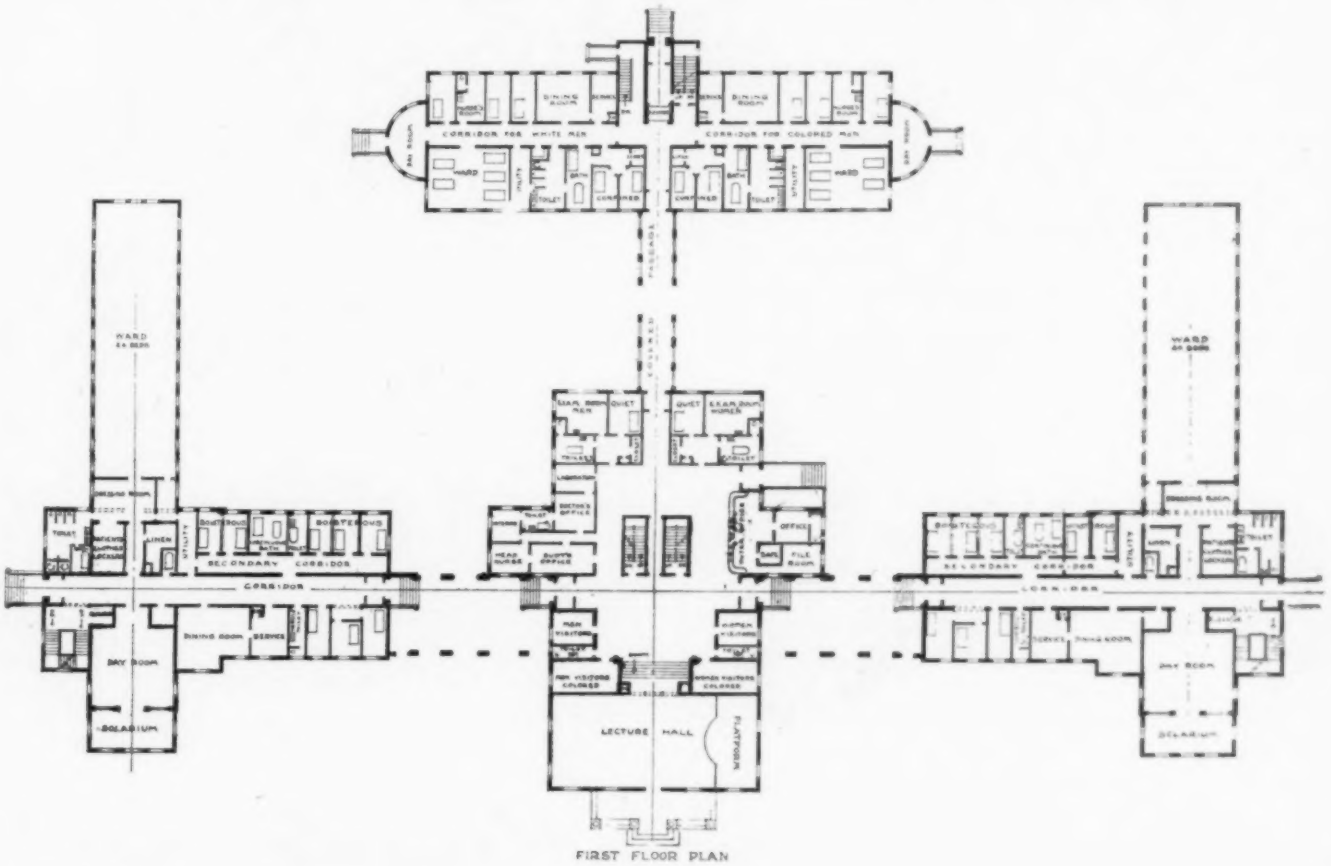
(Upper left) View of the dining room on the east and west wings; (upper right) main entrance and corridor at the front of the main building showing room for consulting staff and visitors; (left center) lecture and assembly hall located on the first floor at the front of the main building; (right center) view of the conference room opening into the main entrance and corridor of the main building; (lower left) interior of living and recreation room located on the first floor, one on either end of the east and west wings; (lower right) view of dormitory east and west wings.

ones most often seen where a patient perhaps already in terror is confronted with the gruesome sight of a human eye, apparently unattached, gazing at him through a door.

These five single rooms have cement floors and floor drains, and in the cement-floored corridor are two hose tips. Evidently the purpose is to be able to turn on the hose and flush the rooms thoroughly. Doubtless this will be a labor-saving procedure, but one finds such floors rather hard and cold. It is hoped that rubber strips or sheets may sometime be provided. The purpose of this secondary corridor and its rooms is to isolate the more noisy patients from the rest of the ward. This is very commendable as a new patient coming into the ward is protected from sights and sounds which might be alarming. The provision of a room for a single bath tub and bed in this disturbed section is admirable. It may be questioned whether there will not be times when a battery of two or three tubs on one floor would be much appreciated. At present such a battery is located in the basement. The control valve for this single tub has been set very close to its head. We believe that it is better to have such apparatus concealed in a recess of the wall so that the operator need feel no concern about its being tampered with by the patient.

The distal end of this secondary corridor opens into the utility room which communicates also with the main corridor and with a passageway to the large ward. In this way the utility room is likely to be a passageway, which may or may not prove inconvenient. The utility room has a wooden floor. An excellent bed pan sterilizer is installed in this utility room. Unfortunately it will not receive the bed pan with a curved pipe at one end which is the type in use at this hospital.

Beyond the dining room and utility room is the crossarm of the wing. Toward the front is a very pleasant day room and still in front of that is a solarium with brick interior walls and plastered ceiling. Where the two arms of the wing cross, the architect has utilized the dark space for a linen room and a capacious clothing room with lockers, not yet installed. At the extreme end of the building is another entrance, a stairway built around a well, and an elevator. Across the hall is a toilet with showers and tub bath. Extending to the rear is a huge dormitory, designed to hold twenty-four beds. One wonders whether the housing of a large number of patients in a ward like this will prove to be a good arrangement in a type of hospital where the overturn is rapid. There is a very happy arrangement of facilities at the entrance to this dormitory. A space thirteen by twenty-one feet has been reserved as a dressing room. At one point it opens into the clothing room and at another into the



FIRST FLOOR PLAN

toilet, hence it will be convenient for patients to remove their clothing here at night, have it placed in the lockers and get it again in an orderly fashion the next morning. On one side of this dressing room is a room five by thirteen feet described as an air lock. This opens at four points into the dressing room, the large dormitory, the utility room, and outward to a small cement-floored balcony. By such arrangements it becomes very easy to get from point to point without disturbing groups of patients wherever they may be located. A larger porch would be preferable.

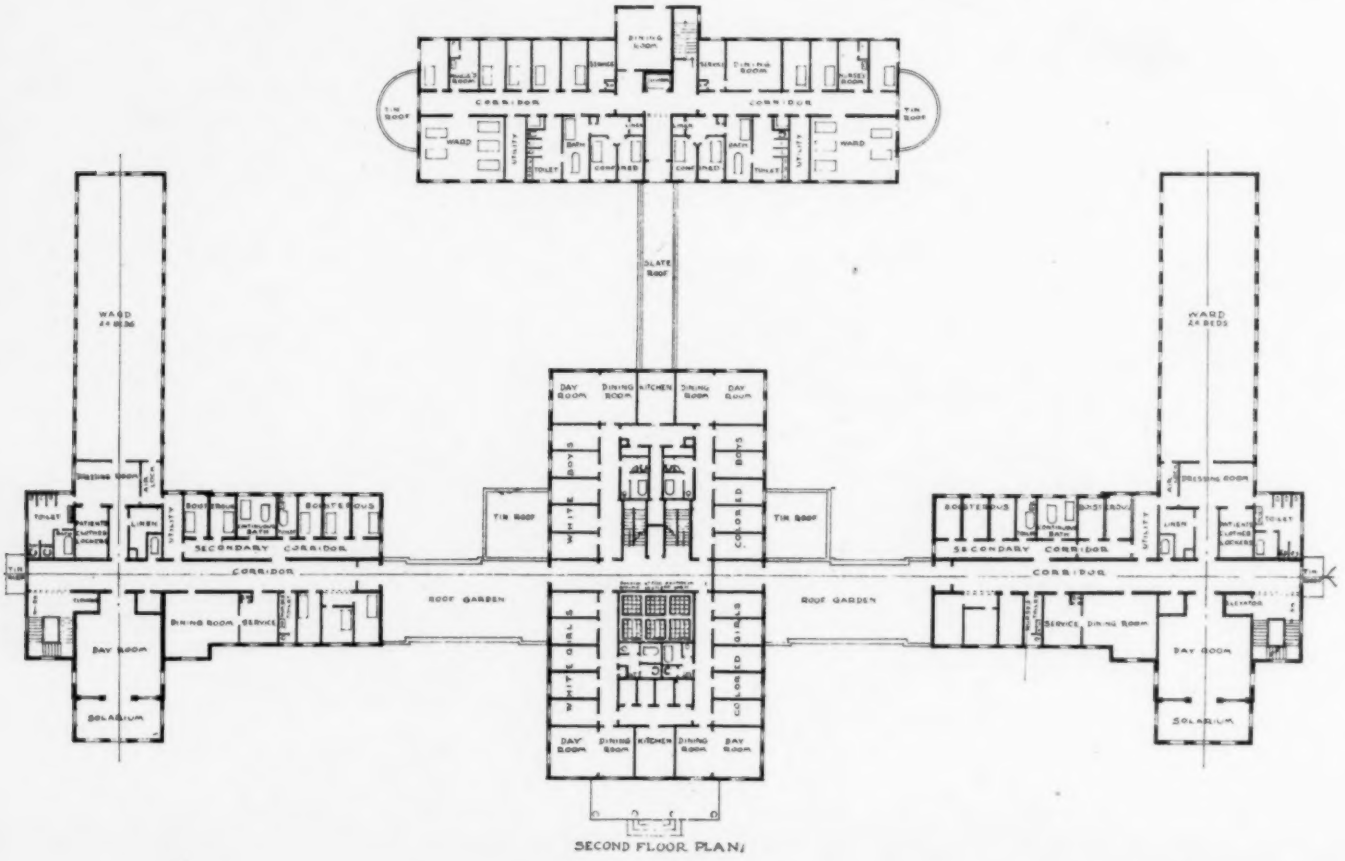
Separate Ward for Deranged Patients

To the rear of the administration building is a separate building connected by a corridor and designated for the "deranged" patients. At present it is the reception service. Again we find the men to the left and the women to the right of the central axis of the building. The division of sexes here is by floors. Men occupy the lower floors, the white at one end and the colored at the other. In addition to the corridor entrance which leads to the main building, there is an entrance at each end into a small semi-circular day room, and a rear entrance that can be used, if desired.

In each of these four wards there are five single rooms and a dormitory for five or six beds, in addition to a bathroom large enough to hold a bed. A private suite is so arranged in each of the four wards of this section that the two bedrooms connect with the bathroom through their anteroom. This bathroom also has doors into the corridor and into the toilet, apparently a very comprehensive and convenient arrangement. The tub can easily be used for giving a prolonged bath. The floors in this building are all of wood. The nurse's room is about half way down the corridor but not so arranged as to give especial observation of what may be going on either in the corridor, ward, day room or the single rooms. The day room is small, but the arrangement permits of the patient's walking up and down the corridor. The dining room for this section can easily accommodate all its patients. No janitor's closet has been provided and one would expect to find the brooms and mops in the utility room, a combination which is often seen, though it is better to have separate provision for the two groups of implements. In the center of this rear building are a stairway and an elevator and in the two diet kitchens are dumbwaiters. The second floor is like the first except that by moving the dining room to the mid-line, space has been given for two additional rooms for white women.

Section Provided for Children

On the second floor of the administration building is a different arrangement. There is no recep-



SECOND FLOOR PLAN

A section of the hydrotherapeutic department in the basement showing douche table and apparatus for medicated baths.

Another view of the hydrotherapeutic room showing needle spray and treatment tables.

tion room. While one can pass from here over the roof to the wings and thereby avoid the necessity of going up and down stairs, it is evidently not anticipated that there will be much travel by that route. This section is designed to accommodate children, girls being to the front of the building and boys to the rear, with lateral separation by colors. For girls of each color there are five good-sized rooms and there is also a central section of four small rooms (evidently designed for very young children) which can be opened toward either the white or the colored girls. The boys of each color will have five rooms. At the four corners of this section are rooms twenty-five feet by sixteen feet nine inches designed to serve both as day rooms and dining rooms. One diet kitchen stands at each end and serves two dining rooms. The natural exercise ground for any of these children who are not in bed will be the roof gardens that will be developed on the passageways over the ambulance entrance and exit. This will probably do very well in warm weather, but one wonders whether healthy children, particularly if they are inclined to be irritable and more restless than normal, will be very easy to manage on a rainy day. This section temporarily houses nurses.

The two wings are arranged alike on the two stories and require no further description.

The basements are high and light and under the central buildings have been put to very good use. Excavation here was continuous from front to rear, hence there is no division into front and rear buildings—when below the ground level it appears to be in a continuous structure. The basements under the wings are usable for storage, if the space is not otherwise assigned. The broad central corridor from front to rear has been divided longitudinally so that all operations for men and women are quite separated. Under the offices is a series of fourteen dressing rooms near an examining room. Next to these is a pack room with space for sixteen tables. Behind this is a room for electric cabinets, then two rooms designed to give Russian and Turkish bath effects, a well-equipped douche room, a small electro-therapeutic room, a massage room with eight tables, a rest room with six beds and an exercise room. All these rooms are provided for each sex. Tubs have been placed in the same room with douches although such an arrangement is not the best. Tubs designed for excited or agitated patients should be immediately off the disturbed ward in a convenient room and should be so arranged that a noisy patient therein will not disturb anyone else. It is equally important that patients in the tub should not be disturbed by the noise of the douches. When the double jet is in full play on the back of some sturdy patient, the sounds resulting are quite disturbing to the peace of mind of any excitable patient. This is particularly the case with women. The comments made by the elated patient in the tub about the quieter and depressed patients who are receiving douches are sometimes disturbingly disconcerting to the latter. This hydrotherapy room is so very well lighted by the glass in the ceiling that it will not be usable in hot weather until the skylight has been painted, or other measures provided to shut off some of the heat rays. It is indeed a very attractive room. The room designed to give the Russian bath has no steam connection. The sink for the pack room happens to be misplaced; this, however, is a small detail. The water pressure can be raised to thirty-eight pounds on each of the two jets. This is not a poor figure, though for use with men, one prefers to be able to get as much as fifty pounds on

both jets at the same time. The small electrotherapeutic room will be insufferably hot.

This is indeed a fine building and in most respects will prove convenient to operate. The subject of casual observation by the nurse, sometimes spoken of as central control, has not been worked out to the last degree. It will not be difficult, however, for her to station herself in the corridor—one always thinks in this connection of where the night nurse will naturally sit—and see most of what is going on. A door at the south end of the toilets would be easier to watch while the day room is in use than is the present entrance to the toilet.

Light fixtures are too vulnerable. They hang at a distance from the ceiling and throw their rays upward. Indirect lighting is very fine in certain types of building and will probably be pleasant here, but it is better, in a building of this sort, unless one is sure that his personnel will be at all times adequate, to use fixtures which are not so easy to damage.

As to the plumbing, one finds as usual that the sinks are low, put at the height which would be convenient for children to use even in places where there will be no children under care. The toilet valves are of the automatic regulating variety, and very fine. They have handles which will probably be removed by the patients in every ward where there is any mischievous person. The spray apparatus is more exposed than necessary or desirable and the showerheads are too high.

The question of proper window guards has given some concern. This is a subject on which there is no general agreement. It is evident that in some section of this building the window guards will have to be made more secure, while others seem twice as strong and numerous as necessary. It is a pleasure to see that in some sections they are not required. The tubs are convenient for prolonged bathing.

It is regrettable that the bedrooms have doors less than three feet wide, so that the rolling of the bed in and out is impossible. Thresholds are found everywhere. This, of course, is an obstacle to the movement not only of a bed but also of a cart with surgical dressings, food truck, or any other moving vehicle. In each wing and on both floors is a rather curious installation. Off the cement floored corridor is a small dark wood-floored room housing a portable tub. At the far end of this room is a spigot from which the tub is to be filled, and after it is filled it must be pulled over a threshold to reach the corridor.

One leaves this building impressed with the amplitude of governmental activity when once a problem has been realized by government officials. The hospital supplants the nearby jail, already marked for removal. This building activity makes very fine provision for mental patients, both those who may be adjudged insane and those who are sent for examination by schools or courts or social agencies. There are, to be sure, some defects in the building. For the most part, these can be corrected and any that cannot be corrected will not seriously impede the activities of those who are administering the building. If now the district commissioners will provide the professional staff needed in all departments, this institution can be developed into a hospital of which the nation may be proud and which will be visited for information and instruction by all those with psychiatric interests who may come to our national capital.

ASSISTING SCIENCE IN DIAGNOSIS

Too often there is a tendency on the part of physicians to be too self-reliant and to be too dogmatic concerning the relationship between cause and effect, or the interpretation of certain findings. For instance, the blood counts, the Wassermann, or the roentgenograms may tell a conflicting story, and unless the attending surgeon or physician takes into consideration the possibility of the existence of certain factors that at times have a tendency to produce contradictory results he may be led astray by the laboratory findings, while at the same time the physician responsible for the laboratory findings is placed in an unfavorable light when in reality his work is not only accurate but trustworthy and deserving of the greatest confidence.

There is not the slightest question of doubt that the laboratory worker should be permitted to interpret his findings, but he can not do this unless he acts in the position of a consultant and knows the history of case, is able to analyze the findings as pertaining to the manifestations, and can determine for himself the limitations of his laboratory work or its contradictions. The fact that he may want to repeat his laboratory examinations and at the second examination reaches different conclusions, in no way minimizes the value or the trustworthiness of his first examination, for the very knowledge acquired as a result of his being placed in possession of the facts concerning the history and symptomatology of the trouble as well as the changing conditions in the patient himself, may have a very important bearing in determining with certainty the final conclusions. Team Work in Practice, *The Journal of the Indiana State Medical Association.*

DR. MUNGER GOES TO WESTCHESTER COUNTY HOSPITAL

Dr. C. W. Munger who for the past three years has been director of the Blodgett Memorial Hospital, Grand Rapids, Mich., has accepted the position of director of Grasslands Hospital, East View, Westchester County, New York. Grasslands Hospital is the county hospital and is under the jurisdiction of the commissioner of public welfare of Westchester County.

A MODERN AMERICAN TUBERCULOSIS SANATORIUM*

By H. J. CORPER, M.D., Research Department, National Jewish Hospital for Consumptives, Denver, Colo.

THE modern sanatorium dealing as it does with all stages of tuberculosis, and in many cases with the various types, presents many problems in caring for these cases which differ materially from those seen in the general hospital. Most of the larger sanatoriums have been forced to abandon to a great extent the purely cottage plan originated by Trudeau and are now built on a sort of compromise between this and the hospital plan.

This change from the cottage plan has been occasioned by two outstanding conditions, the enormously increased per capita cost under this plan and the inability to properly care for real sick patients and advanced cases unless hospital facilities exist in conjunction with the cottage organization. The confusion of the different ideas as to the ideal plan for a sanatorium has led to the adoption of diversified ideas as to the detailed planning of the units for the patients. However, there is a certain uniformity in these units whether they be gathered together in the cottage or hospital plan, since they are all based on the idea of plenty of fresh air and sunlight combined with hygienic surroundings incorporating the possibility of being quickly transformed into closed private rooms for acute emergency and operative cases.

Three Buildings for Adult Patients

Three buildings, the William S. Friedman building, the Guggenheim building and the women's building, house the adult patients in the National Jewish Hospital for Consumptives. The William S. Friedman building, the original unit of the hospital, houses about half of the adult male patients besides containing the main operating room for general surgery, with separate sterilizing and dressing rooms, and private recuperation rooms for the operated cases. The entire building is surrounded with individual open-air sun porches and contains on the main floor the office of the superintendent of nurses, the general linen room of the hospital and a patients' barber shop, besides a parlor for receiving patients' visitors.

The Guggenheim building, the second unit for male patients, accommodates both ambulant and infirmary cases. On the main floor are found the general admission and examination rooms. A feature of this building is the incline which connects the main with the upper floor of the building. This displaces the ordinary stairway, thus relieving the patients of fatiguing stair climbing, besides being serviceable for transporting wheel chairs from one floor to the other. This feature also exists in the women's building which houses the adult female patients, each having an individual room in order to assure privacy. On the second floor of this building there is a general examination room. Both the Guggenheim and women's buildings have all modern facilities for outdoor sleeping connected with the individual rooms. Each building has a large sun parlor for its ambulant patients on the southern exposure in addition to a heliotherapy porch.

Quartz Alpine Lamp Used

The researches of Finsen of Sweden, Rollier of Switzerland and Mayer[1] of Saranac Lake have impressed us with the importance of phototherapy as an adjunct in the treatment of tuberculosis. While the sun can be used efficiently, especially in the higher altitudes, there are times when recourse must be had to the artificial actinic lights. The sanatorium is equipped for this pur-

*This is the second of two articles on the National Jewish Hospital for Consumptives, Denver, Colo., prepared by Dr. Corper. The first article appeared in the December issue, p. 595.

1. Mayer, Edgar. Sunlight and Artificial Light Therapy in Tuberculosis. Amer. Rev. Tuberculosis, 1921, vol. 75.

View of grounds, looking toward Guggenheim building, showing sun parlor and external view of outdoor sleeping porches.

Panoramic view showing grouping of buildings.

pose with the portable quartz alpine lamp which is utilized not only for treating tuberculosis, but has been found valuable in other conditions.

It is common sanatorium practice to treat only adults, regardless of the fact that the disease usually ravages the child in violent form, unless due consideration is given to its eradication during the occult stage. The probable reason for denying the child admittance into the sanatorium caring for adult consumptives is the possible danger of contact infection as the result of carelessness in the segregation of the children from the adults, or in the careless behavior of the adult case. An educational feat will be accomplished when it is realized that, with proper precautions taken to avoid such contact and danger of infection, the child can derive far more benefit in a sanatorium where all the phases of this disease can be treated and thus naturally prevented, than where he is permitted free intercourse with the general population and the proper prophylactic and therapeutic attention is disregarded. Irreparable danger has occurred in traveling from doctor to doctor who is not qualified in this field of medicine, or from hospital to hospital which caters only to acute ills and neglects a malady of the nature of tuberculosis. A potent danger also exists if the child be permitted to remain in family surroundings where intimate contact with an open case is unavoidable.

Features of Children's Building

The Hofheimer children's building,[2] although located on the same grounds, is entirely separated from the main institution. It has its own dining room, kitchen, and linen rooms with kindly matrons and nurses on duty night and day for the watchful welfare of the children. Adult patients do not enter the premises and playgrounds of the children, or *vice versa*. The children's building is modern and fire-proof with all the facilities and conveniences of a modern sanatorium, including outdoor sleeping facilities, isolation rooms, medical examining rooms, treatment room, play room and gymnasium and quarters for the head matron and assistants, also reception rooms for visitors. The children's playground lying south of the children's building includes swings, shoots, merry-go-round, and a field for outdoor games.

The prolonged residence in the sanatorium necessary to ample recovery in many cases, especially in children, would play a tremendous hardship on the education of these children, were it not for the fact that the sanatorium undertakes schooling consistent with the requirements and health of the individual child. Qualified school teachers enlisted from the public schools of Denver are employed to instruct the children in the different

2. Pisko, Mrs. S. The New Children's Building of the National Jewish Hospital for Consumptives, THE MODERN HOSPITAL, 1921, XVI, 404.

Panoramic view of individual rooms for patients in the

National Jewish Hospital for Consumptives, Denver, Colo.

grade studies. In spite of the children's infirmities, accurate data and records kept by the teaching staff show that a child resident in the sanatorium has absolutely kept pace with the more fortunate healthy child of school age, that is, a child who enters the sanatorium while in the sixth grade in the public schools of Denver and remains in the sanatorium for two years is qualified to return to the public school at the termination of this time and enter the eighth grade. Thus, in spite of the illness, there is no actual loss of schooling.

Educational Facilities Provided

The Joseph E. Shoenberg Memorial Industrial School building functions as a school for both children and adults, as patients' general library and reading room, and as an amusement and recreational center. Besides the grade school, classes are given in domestic science, business courses, including bookkeeping, stenography and typewriting, courses in Americanization and vocational training. On the first floor are located the grade class rooms, domestic science room and tailor shop, besides a large cinema theatre in which moving pictures are shown thrice weekly for the ambulant patients. On the second floor are located the business school, patients' library and reading room, and a completely equipped theatre for patients' performances, visiting stock companies and vaudeville shows. These companies give their services gratis for the benefit of the patients who are enthusiastic in their appreciation of the players. This phase of the work is extremely important to the welfare and contentment of the patient during convalescence, the most trying, and probably most necessary period to effect complete recovery and to prevent dangerous relapses, such as frequently occur when the patient returns too quickly to the hazards and strenuous requirements of the business world.

Personnel Adequately Housed

The housing of the nurses and other female employees of the sanatorium is always a difficult problem which is well taken care of in the new Louis D. Beaumont Nurses' Home, erected in 1922 in memory of Dudley Beaumont. It is beautifully furnished and modernly equipped to meet the home needs of this personnel of the hospital, and has facilities for relaxation and recreation most necessary after a fatiguing and frequently depressing day. In this building are two three-room apartments and forty well lighted and ventilated single rooms, two reception rooms and sun parlors, and a large ball room.

The importance of the *cuisine* to the sanatorium, although not stressed at present as in the days when forced feeding was in vogue, is never-

women's building, National Jewish Hospital for Consumptives.

Clinical laboratory, Grabfelder building.

theless still one of the most important as well as most complained of divisions of the sanatorium directly catering to the patient. The problem of meeting the nutritional and health-gaining needs of the tuberculous patient would be very simple, if it were handled merely on a caloric or *nem* basis, but these factors dwindle into insignificance when it is realized that food likes and dislikes are frequently based on many years of bad habits which must be overcome. In addition, the fact that local dietary differences exist in the various parts of the world, not to mention the marked differences existing in the different localities of the United States and in individual families, has to be considered.

Difficulties in Adjusting Diets

Patients, especially those entering a national sanatorium, have as many tastes as there are individuals and when these are distorted and depressed by a disease like tuberculosis any excuse is advanced, to dodge taking the necessary sustenance which may spell success or failure in treatment. Many books have been written on diet in tuberculosis, yet every superintendent and dietitian of a tuberculosis institution is forced to a policy of individualization, especially in bad cases until such time as the food-taking habit is re-established and the palate becomes pleased by a large diversity of dietary foods.

The various patient units of the hospital are provided with well-equipped diet kitchens supplied from the central service building from which the bed patients are delivered their meals properly adjusted to meet the individual requirements. The central service building consists of a large patients' dining room for ambulant cases, a large main kitchen with attached refrigerating rooms, dish-washing rooms, doctors', nurses' and employees' dining rooms on the main floor. In the dining room the patients are given individual waiter service. The kitchen is electrically ventilated to remove all odors occasioned during the preparation of food. The dish-washing room is equipped with electric dish-washing and sterilizing machines to insure clean, sanitary and hygienic supplies of eating utensils free from the danger of spreading infection of any kind. Refuse disposal is taken care of in screened rooms and by means of covered receptacles to eliminate the fly and vermin nuisance.

In a free sanatorium it not only becomes necessary to provide medical, dental and culinary attention but provision must be made for the patients' laundry work to prevent the depression in morale coincident to neglected and untidy bodily habits. This also becomes a necessity since available city laundries refuse to accept the apparel and bed linens from a sanatorium. The sanatorium laundry is housed in a separate one-story building and is equipped with modern laundry machinery including washing machines, centrifugal

Main dining room for children, Hofheimer children's building.

Open air ward, Hofheimer building.

dryers, wringing machines, mangles, pressing and marking machines, besides large steam laundry sterilizers. The power house in the sanatorium does not differ greatly from any other hospital heating plant and includes the steam heating system boilers, refrigerating machines and a well equipped machine shop, besides a large incinerating plant, the latter so essential to the destruction of dangerous refuse and contaminated materials.

Ideal Location for Tuberculosis Care

The hospital site is located near the eastern city limits of Denver within a few blocks of the largest Denver public park, City Park, and within easy vision of the eastern slope of the Rockies. It is in the neighborhood of the better residential parts of the city, occupying two city blocks bounded by Colorado boulevard, Fourteenth, Jackson and Colfax avenues. There is no manufacturing or smoke contamination of the air within miles of the hospital site. The grounds are beautifully decorated with flower beds, grass plots, pine and numerous shade trees, with benches scattered over the grounds where the patients may enjoy the cool balmy Colorado air which is ever present under the shady branches of trees even during the hottest noon day sun of summer. In the center of the grounds is located the Adolph Lewisohn Synagogue where patients, so inclined, may worship. All the walks through the grounds are of durable concrete type which make walking less tiresome and serve for the easy conveyance of supplies between the buildings. The entire ground is surrounded by a Russian olive hedge, with ornamental iron gates at the entrances from the streets. A gravel driveway for the convenience of visitors and consulting physicians enters the grounds circling in front of the Guggenheim Building on Colfax Avenue. The widespread international reputation of the National Jewish Hospital is attested by the large number of signatures in the register of visitors; tourists from all over the world come to see the hospital while visiting Denver and the Rocky Mountain region.

MISS KELLER ACCEPTS SUPERINTENDENCY

Miss Lydia H. Keller has assumed her work as superintendent to the West Nebraska Episcopal Hospital, Scottsbluff, Neb. For the present Miss Keller will turn attention to the securing and installation of equipment for the actual completion of the building in addition to organizing the hospital staff and a school of nursing. Miss Keller has had wide experience in nursing and in hospital work, having been connected with these fields since 1902.

She served on the state board of examiners of nurses in Minnesota for several years and was superintendent of the Asbury Hospital, St. Paul, until 1919 when she resigned to take charge of a nursing school in China for a period of three years. Since that time she has been taking a post-graduate course in nursing and hospital administration at the University of Iowa, and has been lecturing on her work in China.

Beloved, I pray that in all things thou mayest prosper and be in health, even as thy soul prospereth,—III John 2.

One of the research laboratories.

The MODERN HOSPITAL

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GOVERNOR SMITH'S EXAMPLE

GOVERNOR SMITH of New York has appealed to the human sympathy of the whole country by his vigorous, courageous, and prompt action to safeguard the lives of his state's wards in hospitals for the insane, and colonies for epileptics and feebleminded. The disastrous fire at Manhattan State Hospital was not permitted to lapse into a neglected lesson. The executive of the state conceded that humanity demanded consideration at once. He accepted the situation as one requiring leadership by him.

Knowing that these institutions are inhumanely crowded, that many of them possess buildings of great age, dangerous in their plans and locations, and that the fire at Manhattan might be repeated at any time in many places, he startled his people into action by the very grandeur of his recommendation that the general assembly submit to them for their approval, a bond issue of fifty million dollars with which to rebuild, enlarge and expand the state's facilities for these classes of wards. The assembly promptly endorsed the issue. The governor took it to the people, for he did not believe his responsibility ended when the assembly approved the plan.

A campaign of popular education had to be carried on throughout the state. Social, civil, religious, political, fraternal and labor organizations were to be co-ordinated into a working unit for the bonds. In all these matters, he accepted the obligation that was plainly his. He even made a personal matter, the approval of the issue by the people. The magnificent majority of eight hundred thousand for the bonds was a vindication of Governor Smith's courage and foresight. What he has done instinctively should commend itself to the governor of every state in the union. The conditions in New York are duplicated in all other states; perhaps on a smaller scale but of no less serious a nature to those who are exposed to their dangers.

Regrettable as it may be, it is nevertheless true that too many state executives have only a casual interest in their charitable and penal institutions and even less actual knowledge of them. Perfunctorily they speak in behalf of those who live within their walls and express an empty and vain concern for them.

When they are not exploited for aggrandizement of political party or ambitious men, they are neglected for projects which appeal more vividly to the gubernatorial or partisan mind, or promise to be a stronger influence at the polls.

What happened at Manhattan State Hospital happened less than a year later in Chicago State Hospital. It may happen again within this year.

Why may not the big thing in administration that Governor Smith has done in New York be repeated throughout the country without waiting for further catastrophies among the demented and helpless, the unfortunate and the sick, to arouse us to a manifest duty?

WOMEN'S WORK IN THE HOSPITAL

PERHAPS no subject created so much interest at the Milwaukee Conference of the American Hospital Association last October as "Woman's Work in Hospitals." It clearly pointed out that while an auxiliary board is *literally* auxiliary, its work is so clearly defined that it steps out from the ordinary things of the hospital—such as the purchase of cooking utensils, dishes, inspection of linen, running the kitchen and often dictating to the superintendent—into many lines of activity which are necessary to the well regulated hospital; and also pointed out that the successful auxiliary is the one which co-operates fully with the superintendent and the board of managers, with an understanding and unity of purpose. Women's work is of the utmost importance because it introduces a human element in the hospital that is very vital to the patient.

This is seen in the library committee distributing books and giving a word of good cheer; the child's free bed committee collecting funds from Sunday schools and other sources for free beds for sick children; the delicacies committee gathering jellies, grapejuice, preserves, etc., which are so refreshing to the sick; the entertainment committee providing music for concerts, Christmas and other special occasions; hospital bulletin committee co-operating with the superintendent in publishing a monthly or quarterly bulletin, telling the community about the work of the hospital; linen committee; social service committee; intern committee adding to the social life of the hospital; occupational therapy committee; pledge fund committee soliciting pledges from women for the work of the hospital; nurses' home committee acting as foster mothers to the pupil nurses and raising a loan fund for those pupils who are short of money to carry them through their course of training, and many other activities.

At each monthly meeting, there are committee reports, reports from the superintendent, superintendent of nurses, social service worker, occupational therapy and any other department in which the auxiliary is interested. These monthly meetings, together with the bulletin, keep up active interest among the women to the extent that they become influential missionaries for the hospital. They are active in exterminating quacks who prey upon their unfortunate neighbors, they take an active part in clubs, churches, at the polls, and other places in promoting and upbuilding the health of the community.

The women's auxiliary is doing a work in the hospital that is "women's work," and this work develops in them a deeper knowledge and sympathy for suffering humanity and a clearer understanding of their greater responsibility to the community.

THE WARP AND WOOF FOR A PUBLICITY STORY

THERE is an exceedingly interesting story for your local paper, Mr. Superintendent, in the tremendous development of hospital service in the United States and Canada during the past half century. Do you realize its magnitude and diversity? Do you know, for example, that over 1,250,000 people are housed, fed, and cared for each day in the hospitals of the United States alone; that this calls for an expenditure of over $3,000,000 each working day and that the annual expenditure for hospitals and allied institutions goes well beyond $1,250,000,000? You are amazed and interested. So will your next door neighbor be, who perhaps thinks of the hospital only when in the grip of disease and in dire need of its services.

Why not paint this word picture for him in a feature article in your local paper, and at the same time take the opportunity to picture the facilities and accomplishments of your own hospital? The editor will be glad to publish your story and comment on it editorially, if you request him to do so. You will find an ample amount of material for this purpose in "Hospitals of the United States" on page 13 of the fourth edition of THE MODERN HOSPITAL YEAR BOOK. This volume has just recently come from the press and contains the latest authentic information about the hospitals of this country, information of interest to all of our citizens who are fast realizing the important role the hospital is playing in their lives and in their communities.

DECREASING THE MORTALITY RATE OF CHINAWARE

WE HAVE just received a letter from the medical officer in charge of one of the large U. S. Veterans' Bureau hospitals inquiring for some authentic figures regarding the breakage of chinaware in various large hospitals, in order to compare them with figures he has compiled concerning the breakage of chinaware in his own institution.

This inquiry draws our attention again to what

all of us know—the discouraging amount of breakage of chinaware in our hospitals. This preventable loss should compel us to give greater consideration to ways and means of eliminating it or, at any rate, reducing it to a minimum. Does not at least a partial solution of this vexatious problem lie in the greater use of paper products? They may be used to advantage in a number of ways but especially in connection with the food service. Their attractiveness in many instances is such that the old argument of unattractiveness and offended taste no longer holds good. It is not suggested that paper dishes are a universal substitute for present containers but that they have a definite place to be determined within the individual hospital. We believe that as time goes on and hospitals come to realize how much can be saved by the wider use of paper products we shall see them increasingly take the place which they rightly deserve in hospital economy.

TUBERCULOSIS DEATH RATE STILL ON THE DECLINE

RECENT reports from the United States Bureau of the Census indicate that the death rate from tuberculosis is still declining and that during the year 1922 it fell off approximately two points from the previous year and attained the lowest rate on record—ninety-seven per 100,000 population. Reports on file in the office of the National Tuberculosis Association, confirmed by records from the very large insured population of the Metropolitan Life Insurance Company, indicate that for 1923 the death rate will be as low or lower, possibly down to ninety-five per 100,000. Dr. Louis I. Dublin has estimated that, according to all the facts available, the death rate from tuberculosis will probably continue to decline and that by 1930 it will have reached the low mark of fifty per 100,000 population.

The significance of this decline can be read only in the light of the splendid achievements of the National Tuberculosis Association and its affiliated state and local organizations. The campaign against tuberculosis begun in 1904 has penetrated into every part of the United States and has brought with it not only the negative message of prevention of tuberculosis, but the positive message of health building. As Dublin has very well pointed out, to deny the significance of the influence of this gigantic movement would be foolhardy. Everyone will agree, however, that other influences have been at work, such as the improved conditions of living as reflected in increased wages, better housing, and in other ways; the decrease in certain types of immigration; the activities of allied health agencies in other specific fields of work; and a score of other influences too numerous to mention.

If the tuberculosis movement may lay claim to even fifty per cent of the decline in the death rate, which seems reasonable, the energy and money expended reflects itself in a saving of life that is vastly in excess of the investment in health made by the tuberculosis campaign.

BILL CALLS FOR COMPULSORY TESTING OF THERMOMETERS

THE vital subject of regulating the quality of clinical thermometers is again up for active discussion. This is occasioned by the introduction by Senator Copeland of a bill (S1671) providing for the compulsory testing of every clinical thermometer sold in this country, whether manufactured here or imported from abroad.

Realizing that there will undoubtedly be differences of opinion, if not regarding the propriety of regulating the quality of clinical thermometers at least regarding the method of such regulation, a conference on the subject was held at the Bureau of Standards in Washington on January 30. In this conference national associations having a professional interest, state medical associations, government services, trade associations, the trade press, manufacturers and the general public were invited to participate.

As THE MODERN HOSPITAL has repeatedly pointed out the crying necessity of devising some means for protecting the patients in our hospitals against the use of inaccurate thermometers, we welcome the calling of this conference and earnestly hope that it may register itself in favor of recommendations that will make it utterly impossible to market inaccurate clinical thermometers hereafter.

We shall make it a point to inform our readers regarding the results of this conference and shall endorse or oppose its conclusions, depending upon whether or not we regard them as sound.

A HOPEFUL DEPARTURE

FOR years it has been the custom of hospitals seeking funds to base their campaigns upon the principle "many a little makes a much." This has worked well but it necessarily kept "the much" at a smaller figure than could have been used profitably and properly by the hospitals. Wesley Memorial Hospital, Chicago, Ill., evidently has arisen to a higher viewpoint and, consequently, has a greater horizon.

At a recent banquet given by Northwestern

University in honor of Mrs. A. Montgomery Ward, who had given that institution of learning four million dollars, Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, announced that the trustees of his hospital were planning to build in connection with Northwestern University's Medical School a hospital which, with all its departments and their endowment, would entail the raising of twenty-five million dollars. It is the opinion of the hospital that this large amount can be raised with little more difficulty than a smaller amount can be, the principal difference being that people of larger means must be solicited and larger amounts asked. This thought was clearly brought out by Mr. Charles A. Thorn, Mrs. Ward's representative, who stated that she had waited for years to find something big enough to merit the amount she desired to give.

The plans for Wesley Memorial Hospital call for a building containing 300 or 400 beds devoted to medical instruction, a private pavilion of twice that capacity, a children's hospital, an orthopedic hospital, a contagious disease hospital, a neurological hospital, a psychiatric hospital, a nurses' home, and a helpers' home. It is most earnestly hoped that Wesley Memorial Hospital may succeed in this commendable enterprise, thereby ushering in a new era of audacity in asking and generosity in giving.

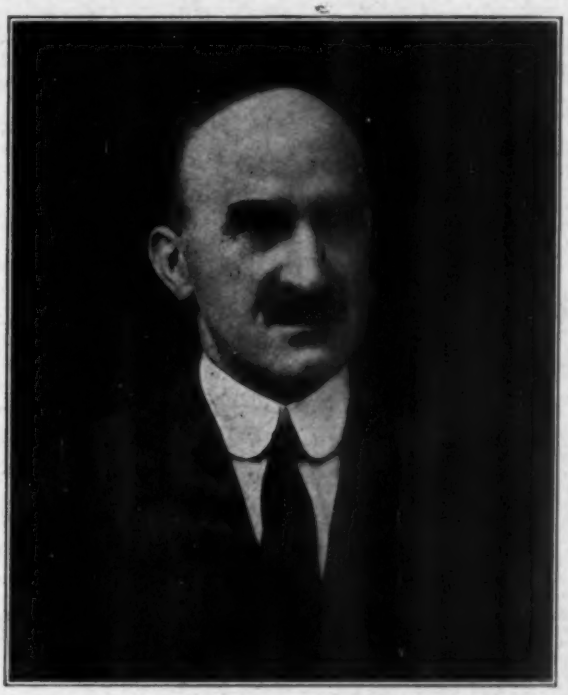
HOSPITAL FIELD MOURNS DEATH OF SIR NAPIER BURNETT

Everyone connected with the hospital field and members of the medical profession throughout the world mourn the passing of Sir Edward Napier Burnett, K.B.E., M.D., which occurred Christmas Morn at his home in London. His death came as the result of prolonged illness following an operation he underwent several months ago when he was obliged to leave the continent and go to Edinburgh.

His distinguished services in the coordination of hospitals during the war will not soon be forgotten. With the aid of Rutherford Morison, he was largely responsible for the organization of the Northumberland War Hospital and up to 1916 was one of the senior physicians there. He then went to London in the capacity of chairman of the economic committee of the Army Medical Committee. After his hospital services during the war he returned to Newcastle.

He had a long and distinguished connection with the Newcastle Maternity Hospital. He made a close study of the whole of hospital organization and effected many improvements in the services. At the time of his death he had still in mind the possibility of coordinating the work of the voluntary hospitals and was working to gain that end. In 1920 he became director of hospitals services under the new scheme whereby the Red Cross was to be stabilized and continue its work of mercy in time of peace. For eighteen months he directed his services to the hospital side of the work. He paid great attention to the economic administration of institutions up and down the country and devoted much of his time to the examination of the finances of hospitals. In 1921 he was appointed chief executive officer of the joint council of the British Red Cross Society which office he still held at the time of his death. His hospital activities were not confined to his own country but were international, as is shown in his interest in hospitals of the United States, and the fact that he was a member of the editorial board of THE MODERN HOSPITAL.

Sir Napier, the son of James Burnett of Fraserburgh,



The late Sir Napier Burnett, K.B.E., M.D., whose death occurred December 25, 1923, at his home in London, England.

Aberdeen, was born in 1872. He took his M.B., C.M. degrees at Glasgow in 1894 and his M.D. degree in 1908 when he went to Newcastle and began practice at Jesmond as a consulting obstetrical surgeon. His reputation as a consultant soon spread, and he was continually receiving patients from all districts of the northern part of England. He was both a fellow of the Royal College of Surgeons and Royal College of Physicians, Edinburgh, a rare distinction. In addition, he held the title, Knight of Grace of the Order of St. John of Jerusalem.

He married Miss Jane McCoull, daughter of the late Mr. George McCoull, Ovington House, Northumberland, in 1903. He is survived by Lady Burnett, four daughters, and two brothers. Funeral services took place December 28, at St. Andrew's Presbyterian church, Frognall Lane, Hampstead. The body was cremated after the service.

ANONYMOUS DONOR FAVORS ST. LUKE'S, CLEVELAND, WITH $2,000,000

An anonymous donor has given $2,000,000 to Saint Luke's Hospital of the Methodist Episcopal Church, Cleveland, Ohio, $1,000,000 of which will be used for endowment, and another $1,000,000 of which will be used for new buildings, on the condition that the board of trustees shall raise $1,000,000 within the calendar year.

The board has purchased a tract of sixteen acres at East 116th Street and Rapid Transit, Cleveland, on which the new hospital buildings and nurses' home will be erected. The new hospital will ultimately have 500 beds.

AMERICAN HOSPITAL ASSOCIATION BUILDS FOUNDATION FOR ENLARGED SERVICES

AN INTENSIVE program of expansion will be carried on this year by the American Hospital Association, as was decided by the trustees of the association in the resolutions adopted at the meeting held January 15, at the headquarters of the association, Chicago, Ill. The text of the resolution follows:

WHEREAS the American Hospital Association after twenty-five years of activity has laid a solid foundation for a much larger and more comprehensive service to hospitals than it is able to give at present, owing to lack of adequate operating income;

AND WHEREAS the American Hospital Association is the one common organization of all hospitals and serving the entire field, therefore it is the organization which should provide the entire hospital field with such a larger and more comprehensive service;

AND WHEREAS the hospital field today is looking to the association for such a service;

AND WHEREAS to carry on this service expert technical assistants on full time and salary must be added to the central office from time to time to make field investigations of all kinds and otherwise to carry on such a work;

AND WHEREAS the association must depend on the revenue from membership dues for the financial support of such activities, requiring that a larger membership be enrolled in order to carry out this larger and more comprehensive service;

AND WHEREAS there are at present 7,000 hospitals and sanatoriums in the United States and Canada, of which only 579 are now institutional members;

AND WHEREAS there are at present over 200,000 executive personnel, trustees and staff members (not including interested contributors) who are eligible to personal membership of which only 1,732 are now personal members; Be it therefore

RESOLVED, that the American Hospital Association during the coming year shall carry out an intensive membership campaign under the direction of the president and executive secretary, subject to the approval of the board of trustees and along the following lines:

Intensive Membership Campaign

(1.) The campaign in each state or province shall be in charge of a state chairman appointed by the president of the association and these chairmen shall each be authorized to appoint as many sub-committees or teams within his state or province as may seem to him advisable.

(2.) The membership campaign committee of the association shall be composed of the state and provincial chairman appointed with the president of the association acting as the chairman thereof.

(3.) The membership campaign committee shall assume such activity as may be authorized by the president and executive secretary subject to the approval of the trustees.

(4.) The work of securing new members shall be correlated in the various states and provinces through the state and provincial chairmen composing the membership campaign committee reporting directly to the president and the executive secretary and through suggestions and instructions from the president and executive secretary to the various states and provincial chairmen.

(5.) The results of the work of each state and provincial chairman in the various states and provinces shall be from time to time announced and published as such.

CONGRESS ON EDUCATION, LICENSURE, PUBLIC HEALTH AND HOSPITALS

The 1924 Congress on Medical Education, Licensure, Public Health and Hospitals will be held at the Congress Hotel, Chicago, Ill., March 3-5 under the auspices of the Council on Medical Education and Hospitals of the American Medical Association. Other organizations participating are the American Conference on Hospital Service, the Association of American Medical Colleges, and the Federation of State Medical Boards of the United States.

Wednesday, March 5, will be devoted to papers dealing with hospitals and public health. In the forenoon the American Conference on Hospital Social Service will present three papers dealing with hospital efficiency, and two reports on hospitals work. The following is the program schedule.

"The Factors Which Indicate Professional Efficiency of the Hospital," by Dr. Ernest A. Codman, Boston, Mass.

"The Measures Which Indicate Efficiency in Hospital Administration," by Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Hospital Activities, Chicago, Ill.

"The Relationship of Autopsy Percentage to Hospital Professional Efficiency," by Dr. L. Hektoen, director, John McCormick Memorial Institute for Infectious Diseases, and Annie Durand Hospital, Chicago, Ill.

"Present Demand for Interns and Possible Use by Hospitals of Non-medical Clinical Assistants and Laboratory Technicians," by Mr. Homer F. Sanger, Council on Medical Education and Hopitals, Chicago, Ill.

"Annual Report of the Hospital Library and Service Bureau of the American Conference on Hospital Service." by Miss Donelda Hamlin, director, Chicago, Ill.

Monday, March 3, will be devoted to papers dealing with medical education including undergraduate and graduate or postgraduate medical work. Tuesday, March 4, will be devoted to a discussion of medical licensure. Wednesday afternoon will be devoted to papers dealing with public health and hygiene.

ILLINOIS HOSPITAL SOCIAL WORKERS SPONSOR LECTURE SERIES

A series of medical lectures in psychiatry, pediatrics and cardiac diseases will be given in Chicago, Ill., under the auspices of the Illinois district of the American Association of Hospital Social Workers Monday afternoons from 5 to 6 p. m., until March 3. The course of nine lectures began January 7. The lectures are given in room 1800, 17 North State St., and are open to all interested in securing a ticket from heads of hospital social service departments or Council of Social Agencies, 308 North Michigan Ave., for the price of $5.

The lectures scheduled are as follows: February 4, "The Prevention of Heart Disease," by Dr. Walter W. Hamburger; February 11, "Heart Disease in Children," by Dr. Fred M. Smith; February 18, "The Glands of Internal Secretion in Children," by Dr. Isaac A. Abt; February 4, "Venereal Disease in Children," by Dr. Clifford G. Grulee; and March 3, "The Undernourished Child," by Dr. Julius Hess.

WHAT IS THE BEST METHOD OF COLLECTING PAST DUE HOSPITAL ACCOUNTS?

COLLECTING past due accounts from patients is one of the most difficult problems which some hospitals have to face. Many institutions require payment in advance as a general working principle, but in practice they often find it advisable to modify their policy to aid the worthy patient who is financially depressed at the time. Such instances often occur where it seems better for the hospital to disregard its set rules and give the patient time rather than defeat the very purpose of the institution and display the characteristics of a commercial establishment.

Extension of time for payment involves risk and is sometimes hazardous, nevertheless many hospitals find that there are times when such a procedure cannot easily be avoided. There are various methods used by hospitals to collect these accounts ranging from ineffective notification of delinquency to drastic measures which involve legal collection. The problem is, in many cases, an individual one and it remains for the particular hospital to find the method which is best adapted to its policies and needs. A consideration of the following methods employed by a few hospitals, may be found helpful, as a basis of comparison.

Personal Letters as Reminders

Wesley Memorial Hospital, Chicago, Ill., requires weekly payment in advance, except in cases where patients are well known or are unable to pay at the time when they need care. The reaction of E. S. Gilmore, superintendent of the hospital, to the question is in part:

"Our plan is to collect our accounts weekly in advance. When a patient enters the hospital his expenses are computed for a week and he is asked to deposit that amount and advised that at the end of the week a bill will be presented for the week to follow. In this way most of our accounts are kept up to date. If a patient leaves before a week has expired, a refund is made. Of course there are patients who are so well known that there is no question about their credit and they pay when they leave the hospital. It sometimes happens that a patient stays longer than he anticipated and is unable to meet his bill in full, when leaving. Also it sometimes happens that patients deliberately get behind in meeting their bills and their physical condition is such that the hospital cannot do otherwise than keep them until discharged by the physician. In such cases we attempt to collect before the patient leaves and, if unsuccessful, take the patient's note if he will give it.

"If the note is not paid, when due, all reasonable courtesy is shown in the way of giving him time to pay; we remind him at monthly intervals that the account is due. We have no form letters for this, but write a personal individual letter to fit the case. When our methods have proved unavailing, the account is turned over to a collector who will follow the usual methods of a collecting agency. Of course it is evident that the patient is really unable to pay his bill it is not pressed, but cancelled instead. We have no desire to collect from anyone who ought not to pay."

Third Letter Proves Winner

The Touro Infirmary, New Orleans, employs a system of follow-up letters briefly described by Dr. John D. Spelman, superintendent.

"A new system of collecting accounts was put into effect here over a year ago and the result obtained would tend to assure its success. In the first place, we publish in each room a notice that we require payment for one week in advance and retain the right to transfer to the open ward any patient whose account is not liquidated within seventy-two hours. Of course, this is a measure we do not use except when circumstances indicate its desirability. I would say that the majority of our patients are not required to make payment in advance but when at the end of the week their account is not met, we assure ourselves that the individual responsible for the bill is reliable, or make very persistent attempts to have the account liquidated.

"All patients leaving the institution are referred to the front office and the accounts receivable may thus be checked to see if there are any payments due. If the patient leaves without liquidating the account a statement is mailed immediately; ten days later, another statement with the added caption 'Please remit' is sent. Again, after ten days another letter is sent the substance of which follows:

> Several statements have been rendered for the sum of $..... due this institution. We shall have to hear from you at once on this matter, as we are dependent on prompt collections in order that we may meet our current expenses. If you are not able to meet all of this account at once, you will please call upon our accountant and make proper arrangements.
>
> Yours very truly,
>
> .....

"A second letter similar to the following is sent ten days later.

> We have mailed you several statements and also called your attention by letter to your account which is outstanding, but, up to this writing, we have not had a response. Unless we hear from you within the next few days, it will be necessary for us to hand your account to our attorney for collection. We would very much regret to have to take this course and trust you will let us hear from you at once.
>
> Yours very truly,
>
> .....

"If response is not made, a third letter, a letter originated in our office written on attorney's stationery, is mailed ten days later.

> Your account of $..... due Touro Infirmary has been referred to us for collection with the authority to take such steps as may be necessary to obtain results.
>
> If you fail to make satisfactory arrangements with the accountant of Touro Infirmary within the next week, it will be necessary for us to take action to press payment.
>
> Yours very truly,
>
> .....

"By far the greater percentage of collectible accounts, even though letters have been disregarded, are forthcoming upon receipt of the attorney's letter and, without reference to the letter, many liquidate their accounts or make satisfactory arrangements to do so. Those accounts which require the service of an attorney are handled from this point directly by the attorney's office. While it is true that we have had to charge off a number of accounts, at the same time, we have not yet in a single instance been

required to bring action in the courts for the collection of an account."

Credit Bureau—The Final Collector

The Hartford Hospital, Hartford, Conn., employs a follow-up system of statement and letters for collecting unpaid bills. If the series of statements with stickers attached fails to response a series of letters is sent. If, in turn, these fail, the account is given to the Connecticut Credit Bureau to collect. Dr. Lewis A. Sexton, superintendent of the hospital, describes the system as follows:

"If, for any reason, patients leave the hospital without having adjusted their account satisfactorily, we send them monthly statements for two or three months. If no response is received, we send a statement on which is placed sticker No. 1. If, by the first of the following month, we have not heard from them, we send another statement containing sticker No. 2. If response is not forthcoming at the beginning of the next month, we send the same statement containing a rubber stamped notice.

"When patients do not respond to the itemized statement the bill below is sent on which is placed sticker No.

Hartford, Conn., ... 192...

To HARTFORD HOSPITAL, Dr.

To ..... Weeks Board and Care of .....
from ....., 19..., to ..... 19...,
inclusive, at $..... per week.....$.....
from ....., 19..., to ..... 19...,
inclusive, at $..... per week.....$.....

NOTE—It is our custom to charge day of admission and day of discharge as full days.

To Operating Room Fee ....
To Case Room Fee ....
To Special Nurse's Board..... .....
To X-Ray ....
To Laboratory ....
To Extras ....

Received payment,
....., Supt.

All Bills Payable Weekly in Advance

HARTFORD HOSPITAL

Hartford, Conn., ..., 19...

Folio.....
.....
.....
.....

TO BILL RENDERED.....

The rule of the Hospital is that all bills are payable weekly in advance.

This account is overdue.

A prompt remittance will be greatly appreciated.

HARTFORD HOSPITAL.

1., on which is printed in conspicuous red type: 'Undoubtedly this matter has been overlooked. An early response will be much appreciated.' A month later the bill is sent on which sticker No. 2 bearing the following words is placed: 'Your attention is called to this matter which has been standing some time. An early settlement is respectfully requested.' At the beginning of the next month the bill is sent on which is the rubber stamp notice 'PAST DUE.' This account has no doubt escaped your notice. Will you please favor us with a remittance by return mail, and oblige.

"In the same manner, at the beginning of the next month, we send letter No. 1. Letter No. 2 is then sent at the beginning of the following month. If, in the meantime, we have heard from them and they promise to make a payment at a certain time and fail to comply with the promise we send them a third letter which is self-explanatory. If this entire procedure does not have effect, the account is immediately given to the Connecticut Credit Bureau for collection. This bureau has the ability to collect money, if any exists, without offending the man from whom it is extracted.

There is also a law in Connecticut imposing a fine of fifty dollars or thirty days in jail or both for leaving a hospital without satisfactorily adjusting the hospital bill."

The three letters which follow are all sent out on the regular stationery of Hartford Hospital.

(Letter No. 1)

Dear Sir:

We have previously sent you several statements of your account, as it appears on our books, but as yet we have received no reply.

Possibly your reply has gone astray, or you may have taken the matter up with some one in the office who has not given it proper attention.

We wish to extend every courtesy in the settlement of this account, and if there is any reason why you are withholding payment, may we ask that you kindly inform us at once?

An assurance of your cooperation will be appreciated.

Yours very truly,

....., Superintendent.

(Letter No. 2)

Dear Sir:

We wrote you on ..... calling attention to the amount which you owe the Hartford Hospital. Statements have been sent you on several occasions.

We are particularly anxious to avoid making you any further expense, but if you are not heard from, or a remittance received from you within ten days, your account will be placed in the hands of our attorney for collection.

We trust, however, that this step will be unnecessary, and will look for an early remittance.

Yours very truly,

....., Superintendent.

(Letter No. 3)

Dear Sir:

We have waited several days since the date set for your promised payment on account.

Credit was extended to you in the firm belief that you would meet your obligation when the same became due. We accepted your promises to pay with the same degree of trust and confidence, and sincerely hope you will demonstrate your appreciation of the many courtesies extended you, and not allow anything to interfere with your immediate attention to this matter.

Awaiting your reply, we are,

Respectfully yours,

HARTFORD HOSPITAL.

COMPILE LIST OF BOOKS ON PHASES OF PUBLIC HEALTH

A list of selected books on the various phases of public health has recently been compiled and is ready for distribution by the National Health Council, New York City. The list contains 175 titles grouped under the headings, administration and general public health, cancer, child and maternal hygiene, communicable diseases, foods and nutrition, health education, industrial hygiene, laboratories, mental hygiene, personal hygiene, public health nursing, sanitary engineering, school hygiene, social hygiene and tuberculosis. A list of magazines on public health subjects is appended. The bibliography is intended to furnish to sanitarians and others interested information about the best books and journals on public health.

INTERN PROBLEM TO BE INVESTIGATED BY A. M. A. COUNCIL ON MEDICAL EDUCATION

A THOROUGH investigation of the intern problem is being undertaken by the council on medical education of the American Medical Association which is sending out questionnaires to hospitals of whatever type of twenty-five beds or more in the United States, its possessions, and Canada, including in all about 4.400 hospitals. Along with the questionnaire is sent a blank for the names of interns serving in the hospital.

The work has been undertaken by the council in response to the request of the intern committee of the American Hospital Association and the trustees of the American Conference on Hospital Social Service representing the hospital field. The questions asked cover the information desired by all who are interested in the supply of interns and resident physicians, as well as the practicability of training non-medical clinical assistants, and the demand for them. The information which is being gathered will be digested and published for the benefit of all hospitals and others concerned so that it is requested that every hospital return the questionnaire, regardless of whether it uses interns or is at present interested in the problem of non-medical clinical assistants.

Two Blanks to Be Filled Out

Two blanks are being sent to every superintendent of a hospital having more than twenty-five beds. The first is a questionnaire covering the intern situation by the following questions: How many interns do you require? How many do you have now? How are interns appointed (by competitive examination or by appointment)? When do internships begin? When do they end? Length of internships in months. Do you offer an extension of intern service for a longer period to interns desiring it? If so, what is the maximum length of internship you offer? If you do not offer an extension, could you do so? What salary per month could you offer for this additional term? Are you in a position to offer internships in specialties for those who have already served a general internship? How many such internships could you offer? In what specialties, giving length of time in specialty? Are women interns admitted? Do interns receive experience in out-patient work? In accident cases? In necropsies? What salary, if any, per month? If other method of compensation is employed please describe it here. Do you admit and use medical students as interns? Do they reside in the hospital? In what school years? How many? How long do the students serve? What are their daily duties? Are you able to get on with fewer regular interns because of the aid given by these students assistants? Do you have resident physicians other than interns? If so, how many? How long do the residents serve? What is their salary? What are the duties of your resident physicians?

Questions Cover Entire Situation

In view of the insufficient supply of interns the following list of special questions is asked: Do you use in your hospital non-medical, clinical and laboratory assistants or technicians? How many? Could and would your hospital employ non-medical, clinical assistants who are properly trained to write histories and do other bedside work exclusive of physical examination and also perform the simpler clinical laboratory tests? Is it your opinion that these non-medical clinical assistants could supplement and aid the interns of your hospital? Is it your opinion that properly trained non-medical clinical assistants serve in the place of interns when the latter are not obtainable? How many non-medical clinical assistants would you require in addition to what you may have now? What salary could your hospital afford to pay these assistants? What would be their duties?

The following blank is to be used for listing the hospital's interns.

Council on Medical Education and Hospitals
of the
AMERICAN MEDICAL ASSOCIATION

LIST OF INTERNS

Please return this blank, filled out and signed, to the Council on Medical Education and Hospitals, 535 N. Dearborn St., Chicago, for which stamped envelope is enclosed.

Name of Hospital.....

Street and Number..... City..... State.....

Names of Interns at Present In Hospital	MEDICAL COLLEGE	Year of Graduation	Internship Expires	
			Month	Year

Names of Interns who have Left Hospital During Past 12 Months	Medical College and Year of Graduation	Please Insert Present or Home Address (If large city give local address)

Information furnished by.....
Medical Director or Superintendent
(Erase title not used)

Date.....

SOME ECONOMIES WHICH MAY BE EFFECTED IN THE SMALL HOSPITAL

By H. C. WRINCH, M.D., Medical Superintendent, The Hazleton Hospital, Hazleton, B. C.

MUCH of the success of effecting economies in small hospitals will depend upon the character of the relations existing between the executive officers of the institution and the tradesmen of the town or district served by it. A relation of most cordial and constructive sympathy must be established between these two elements *before* active steps can be taken successfully along the lines suggested later in this discussion.

The people of any town or district contiguous to a hospital are of a necessity the ones most interested in the successful operation of such a hospital, for it is for their care in time of sickness that the hospital exists. Usually it is they who have called it into existence, and their delegated representatives are endeavoring to finance and carry on the institution. In view of this, it is strange yet unfortunately too true, in many cases, that a certain number of these local people make the administration of the hospital a much more difficult task than it needs to be.

The people referred to are the local merchants who in some cases insist that the hospital shall purchase from them at full retail prices, all supplies and stores that it can obtain locally. It is probable this is done more through a natural desire to obtain business, and, in ignorance of the handicap, they are placing upon their own institution, than from direct intent to impede the development and hinder the work of the hospital.

Cooperation of All Classes Needed

In the effort to institute economy of administration, the first move therefore of the management of the institution is to enlist the active cooperation of all classes of the community. This will be accomplished by showing them that the institution is their institution, its interests are their interests, and that its interests require that its funds be made to go as far as possible.

It will require no elaborate argument to show that if all supplies are bought at wholesale rates there will be a great saving to the hospital. Almost all wholesale houses are willing to sell to hospitals direct, if the local retailers will consent. Provided that it is put before them in this way, there will be found that few communities where people will not agree to their hospital availing itself of this privilege. The writer has tested this on two occasions and found no difficulty. This applies more particularly to groceries and general household supplies.

Winter vegetables, e. g., potatoes, turnips, carrots, can generally be bought much cheaper in the fall than any time later. A good storage cellar will make it possible to buy these at lowest rate and carry them through till needed. This will apply equally to apples, and also to eggs, if the latter are secured sterile early in the summer and treated with waterglass or other suitable preservatives.

As to summer fruits and certain of the perishable vegetables, the kitchen staff, with perhaps a few days' assistance from extra help, can preserve a large quantity of these in a minimum of time by means of the home canning machines which are now on the market. In a small community, often the people will be found willing to give voluntary assistance to the hospital staff during canning and preserving seasons. Not only is a great saving effected in this way, but the storeroom shelves of the institution will thus be filled with a far more appetizing stock than if regular canned foods are used. This practice can be extended to meats, and to certain kinds of fish, where such are obtainable.

Economy Effected by Summer Garden

It often happens that the hospital is located in a favorable locality for growing summer fruits and vegetables. In many instances the janitor, whose time is fully occupied in tending to furnace and stoves during the winter, can be profitably utilized in summer in the vegetable and small fruit garden. A little extra help may be necessary in the garden at certain seasons of the year. If so, such extra assistance will well repay the outlay.

In regard to buying meat in summer, for an institution which cannot use a quarter of beef within the time it will remain fresh, should arrange with a local butcher shop (assuming, of course, that the proprietor is a sympathetic hospital supporter) to sell a quarter at a time, allowing the hospital to take what it needs of it each day or so, and allow the remainder to be kept in the cooler of the store.

Instead of buying absorbent cotton in small quantities from surgical supply houses, it can be obtained from the big cotton mills in the eastern states in bales of 100 pounds. Two different grades can be kept so as to use the cheaper kind for rough dressings.

A very considerable economy can be carried out in the laundry; first, by having a laundry in connection with the hospital instead of sending everything out; and second, by buying direct from some soap manufacturer, barrels of scrap soap, instead of the regulation sized bars or cakes, as they appear on the market. This scrap soap is the irregular sized pieces of fragments broken off when the blocks are being cut into bars or cakes and can be bought for about thirty per cent less.

The foregoing methods are not merely theoretical suggestions. They have been worked out in practice, and are commended to any who wish to put them to the test.

St. Louis Hospital, Paris, France, a pioneer among the hospitals of that city.

BENEFITS AND DISADVANTAGES OF HOSPITAL ENDOWMENTS*

By EDWIN R. EMBREE, Secretary, Rockefeller Foundation, New York, N. Y.

THE REAL endowment of any institution might well be not only money but desire and ability to meet fresh needs as they come, to set new standards in succeeding generations. Coin of that mintage can never be too plentiful among the assets of any hospital. "The man who creates new needs and new desires is the best benefactor," says Bernard Shaw.[1] Trustees and citizens who constantly point out modern opportunities for advance and insist upon meeting fully developing needs are the real donors to hospitals.

This, however, is not the type of endowment to which institutions, generally, have been heir. Capital value in buildings, in rented real estate, and in interest-bearing stocks and bonds are the types of things which, for a thousand years, hospital trustees have been recording as permanent assets in their books. I am by no means disposed to belittle the value of such property to any institution of public service. Such lasting endowments have often made it possible for important hospitals and colleges to continue their good work century after century. The giving of money in order to establish, for future generations as well as for the present, institutions for the education of the young and for the humane care of the ill and unfortunate has been one of the fine expressions of enlightened altruism throughout modern history.

As a background it may be well to recall how old is the idea of institutional care for the sick and how thoroughly established in connection with it is the practice of providing lasting endowments.

The Market—The Hospital Precursor

The germ[2] of the hospital idea may have been in the ancient Babylonian custom of bringing the sick into the market place for consultation. The Egyptians and Greeks held primitive clinics in the temples and there is reason to believe that housing for the care of the sick was developed in both Egypt and Greece long before the Christian era. In India records indicate that hospitals were numerous 300 years before the birth of Christ. Hospitals founded by the Emperor of Hindustan as early as 260 B. C., contained provisions so extensive as to be quite comparable to modern institutions.

With the advance of the Christian Church, hospital building increased so rapidly and has continued so consistently that some attribute organized care of the sick to Christianity. The early Christian infirmaries were founded in direct connection with the church and were supported from its revenue.

A few of the hospital foundations which have persisted from the Middle Ages have interesting histories and splendid records of service.

St. Bartholomew's Hospital, "Bart's," as it is known in London, celebrated its 800th anniversary this spring. Rahere, the court jester, (so the story goes in the literature of the commemoration ceremony) repenting of his vain and frivolous life, went on a pilgrimage to Rome. On the way he became ill and thereupon vowed that if he recovered he would found a hospital. Later St. Bartholomew appeared to him in a dream, reminded him of this vow and suggested that he build a church also. With the aid of the bishop of London, Rahere gained a grant of land from King Henry I, the very tract upon which "Bart's" stands today, and has stood with repeated rebuildings for 800 years.

Harvey, the discoverer of the circulation of the blood, was appointed physician to the Hospital in 1609 and held the office for thirty-four years. Medical education in connection with this foundation, according to the earliest records, began in 1662 when students were reported to be in the habit of attending medical and surgical practice in the wards. This was the beginning of one of the great present hospital medical schools of London.

St. Thomas' Hospital, whose buildings now form the beautiful range on the Albert Embankment just across from Parliament House, goes back in its foundation[3] to times probably preceding St. Bartholomew's. Long before the Norman conquest, a pious maiden, Mary, built a small convent on the banks of the Thames from funds acquired from a profitable ferry. In 1106 this house became the Priory of St. Mary Overie and cared for the sick of the city and was later united with the hospital of Bermondsey and named in memory of the martyr, St. Thomas of Canterbury.

Had First Modern Nursing School

A chief modern interest of St. Thomas' is that in this hospital in 1860, Florence Nightingale founded the first great modern school for nurses' training. Records and regulations still in existence reveal the significance of the changes which this school brought about. . . . .

The Hôtel Dieu of Paris is believed to be the oldest of the hospitals of Europe with a history of unbroken service, a service which continues at high standard today.

A still earlier French foundation, but one without a record of continuous service, is that of King Childebert in Lyons dating from the sixth century and represented today in the beautiful building by Soufflet, also called Hôtel Dieu. . . . . *La Charité*, the great infirmary which today adjoins the Hôtel Dieu on the banks of the Rhone grew from the gift of a wealthy woman of Lyons. In the beautiful *salle de conference of La Charité*, surrounded by exquisite sixteenth century work carvings, I was present last summer at the organization meeting of a notable new school of nursing sponsored by a committee the head of which is the dean of the medical faculty. In this old hospital which has looked on grimly at human suffering for hundreds of years, which with good enough

*Abstract of paper presented at the Conference of the American Hospital Association, Oct. 31, 1923, Milwaukee, Wis.

1. In Fabian Tract No. 107, under the title "Socialism for Millionaires," Mr. Shaw makes some fresh and stimulating comments on the art of giving.

2. The classic authority on hospital history and administration is H. C. Burdett's Hospitals and Asylums of the World, published in London in 1893, with periodic supplements. Other standard histories include F. H. Garrison—An Introduction to the History of Medicine and Medical Chronology (with bibliographical data) Saunders Co., 1921; A. J. Ochsner—The Organization, Construction and Management of Hospitals, Cleveland Press, Chicago, 1909; C. Tollet—Les édifices hospitaliers depuis leur origine jusqu' à nos jours, Paris, 1892; W. G. Wylie—Hospitals, their History, Organization and Construction, Appleton, 1877.

3. Interesting accounts of individual hospital foundations include: The Hôtel Dieu of Paris, U. S. Naval Medical Bulletin, 1918, vol. 12, pp. 653-693; D. L. Mackay—A Thirteenth Century Hospital, Modern Hospital, July, 1921, vol. 17, pp. 10-14; G. Q. Roberts—A Brief History of St. Thomas' Hospital, London, Photochrom Co., Ltd., 1920; The Medical College of St. Bartholomew's Hospital in the City of London, University of London Sessions, 1922-23. In addition, references in this paper are based upon visits last summer to the archives of St. Thomas' Hospital, London, and La Charité in Lyons.

intentions has allowed that suffering to be so much increased because of poor nursing and neglect of even primitive sanitation and care, was born a school not only for the best modern training for sick care, but a school dedicated to training chiefly for public health, for child welfare, for preventive work in the homes and instruction in the schools.

This significant new institution has grown directly from a union of new ideals with these 1400 year old foundations. It represents the determination both of those responsible for the hospitals and of those interested generally in medical care and public health in Lyons to have these old institutions meet new needs with improved standards and by fresh methods.

Wise Use of Endowments—Fundamental

These are but examples indicating the early and firmly established place which hospitals have in the life of civilized peoples. They illustrate what endowments, retained and added to from age to age, may do in preserving worthy institutions. They make it clear that foundations in wise hands guided by intellectual resourcefulness and imagination, may adapt themselves to new needs, may continuously raise their standards and revise their methods in meeting the new demands of succeeding generations. These are elementary and fundamental considerations with respect to hospital establishments. It would be unwise and unfair to underestimate the importance of endowments in the history of hospital service.

May not the danger, however, be on the other direction? It is not a common tendency to assume that the raising of funds and the accumulation of large endowments are the all important functions of hospital trustee? Recognizing and giving all due weight to the record of ancient and rich foundations, should not the prime emphasis be given by trustees, not to the amounts of money which they can raise but to the uses to which these sums are placed?

Unfortunately for every example of the Hôtel Dieu in Paris that has come down with splendid and ever improving service, there are dozens, if not hundreds of houses, homes, hospitals and charitable foundations that have died of inanition, that have wasted of dry rot. The significant thing about St. Thomas' is not its pre-Norman beginning, but its service through Florence Nightingale to a new school of nursing. "Bart's" 800 years of history are glorified and made significant for this generation by its present excellent care each year for 9,000 ward patients and for 300,000 dispensary calls and by its present great contribution to medical education.

Neither should we be unduly impressed with the mere continuation of service of a single institution. If St. Thomas' with its thousand years of history had not been at hand, nurses' training would not have suffered irreparably by being launched in a hospital but a hundred years old or even two weeks old. Not its antiquity but its willingness and ability to be of service formed the distinguishing feature of St. Thomas' in the founding of modern nursing.

Nor should we forget that those institutions which expend themselves in a single great gesture often are more nearly immortal than those which continue a physical existence. It was really in the temporary military barracks of Scutari that Florence Nightingale began her great work. There modern nurses' training really had its birth. The fact that no endowment continues that groups of shacks now mouldering on the Asiatic shores of the Bosporus, in no way dims the brilliance of the contribution to education and to humanity made by this hospital.

As a matter of fact not seldom does it appear that the very age of a foundation makes it difficult for it to adapt itself to fresh needs; that the very richness of its treasury makes an institution unresponsive to new opportunities. In such cases endowments dry up and cease to have value. It would be much better for such establishments to expend themselves while they can recognize and meet existing demands than restrict such early work to preserve funds for unadapted and ever diminishing service.

Furthermore, it should be born in mind that only by expending and so reducing the financial wealth can the hospital increase its value to the community in scientific advance, in education and in humane care. And it is for those services, not for the accumulation of property, that such institutions are created.

Look, for example, at the case of *La Charité*. For years thrifty trustees had been laying by small surplus sums. When the new nursing school was proposed it aroused the greatest anxiety in the souls of the more cautious directors. There was much shaking of heads and studying of ledgers. "We can lay by ten thousand francs a month," the reactionaries said, "if we simply go on as we are now." "And no one knows," the treasurer cried, "but that these new fangled plans may eat up all our recent savings and even eat into our ancient endowment!" Only by reducing the book assets of the treasury could real wealth in care of patients and education of nurses be given to Lyons and France by this hospital.

In such a case there is a direct ratio between the riches of the treasury and the poverty of service; the reduction of funds and the increase in the real wealth of the community served.

In another and very material way expenditure increases wealth, that is, by attracting new resources to support new features or improved standards. Every hospital trustee has had the experience of seeing new ventures bring in new support, often in quantities that far exceed the extra expense of the specific project.

A further consideration in behalf of creating wealth by expending funds applies peculiarly to medical and health agencies. As all available resources are expended in giving the greatest possible service in curing and preventing disease, in educating doctors and nurses and in furthering science, it is fair to remember that health itself is, or may create, wealth, that knowledge is power, and that the extension of science often extends widely both the bounds of service and the means of giving that service. To take a couple of simple, striking cases: may it not be better to exhaust all available funds in eradicating typhus in a district of the East, than to preserve an endowment to give hospital care to continuing cases? In a village of the south may it not be sound finance as well as good hygiene to use all present assets in eradicating hookworm, relying upon the increased wealth of a revived people to assume the burdens of the next generation?

If trustees are to be influenced by such principles as I have suggested they must, of course, be truly interested in the community to be served and in its needs rather than chiefly in the prestige of the particular institution with which they may happen to be associated. One of the astonishing exhibitions of the competitive impulse is the institutional rivalry between organizations originally created to serve the common good. Occasionally, also, moved either by competitive motives or the corporate instinct of self preservation, hospitals established to relieve suffering and promote health and education main-

tain shockingly unhygienic working conditions, some make new suffering by driving harsh bargains with labor and by exploiting pupil nurses. This anomaly tends to disappear in direct proportion to the breadth of view of the trustees responsible.

Incidently, it is well to remember another interest both of the community and of the institution, the question of the ability of a given board of trustees. Every board should periodically examine itself, coolly and as objectively as possible, to make sure that it is thoroughly conversant with the real problems of its institution, both those of finance and those of professional service, that it is not made up exclusively of old men or of any other special or narrow group, that it is refreshing its councils by adding, from time to time, new blood and fresh perspective to its membership.

For the most part, we have been considering very general principles. It would be folly to attempt to suggest specific canons in the matter of accumulating or expending funds with any idea that these would be universally applicable to different types of institutions under widely varying circumstances. Individual groups of trustees, however, in making decisions concerning their own institutions may do well to keep in mind the various general methods of financing in wide use.

First there is the restricted endowment. The sum left at Oxford during a famine in order to make provision that half a loaf of bread be left every morning at the door of each student of a certain college group, is an extreme instance of restricted trust. This half loaf still scrupulously placed each day before each door in a group of dormitories strikes one as being scarcely the most fruitful use of funds in a great educational center. Another instance is the Dudley endowment for an annual lecture at Harvard University on "Natural and Revealed Religion, Corruption of the Church of Rome and Validity of Presbyterian Ordination," a foundation on which it is rumored that Cardinal Gibbons once lectured in Cambridge. This type of minutely restricted endowment is now so thoroughly discredited that many groups refuse to accept trust funds unless broad discretion is allowed in their future expenditure.

Second, there is general endowment providing perpetually for the entire needs of an institution. In the very security and ease of such a condition there is great danger of dry rot; of bureaucratic tendencies in the personnel, of disassociation from current needs. I have in mind at least four hospitals and two dispensaries whose service has actually been stultified, for, having funds sufficient perfunctorily to carry on present work, the trustees are unwilling to consider revisions of program, raising of standards, or any real response to modern needs.

At the other extreme, an institution may be entirely dependent upon current contributions to meet all expenses. This is essentially the condition of state or publicity supported institutions. It represents probably too precarious an existence for a hospital depending upon private voluntary contributions.

The middle ground, on some part of which it is probably wise for trustees of privately supported hospitals to take their stand, is that where permanent endowment or accumulated reserve or working capital takes care of a part of annual expense, particularly the educational work, and guarantees continuing service at adequate level, while current revenues and regular contributions year by year and generation by generation, meet the major part of current cost and take care of buildings and new projects as these are demanded.

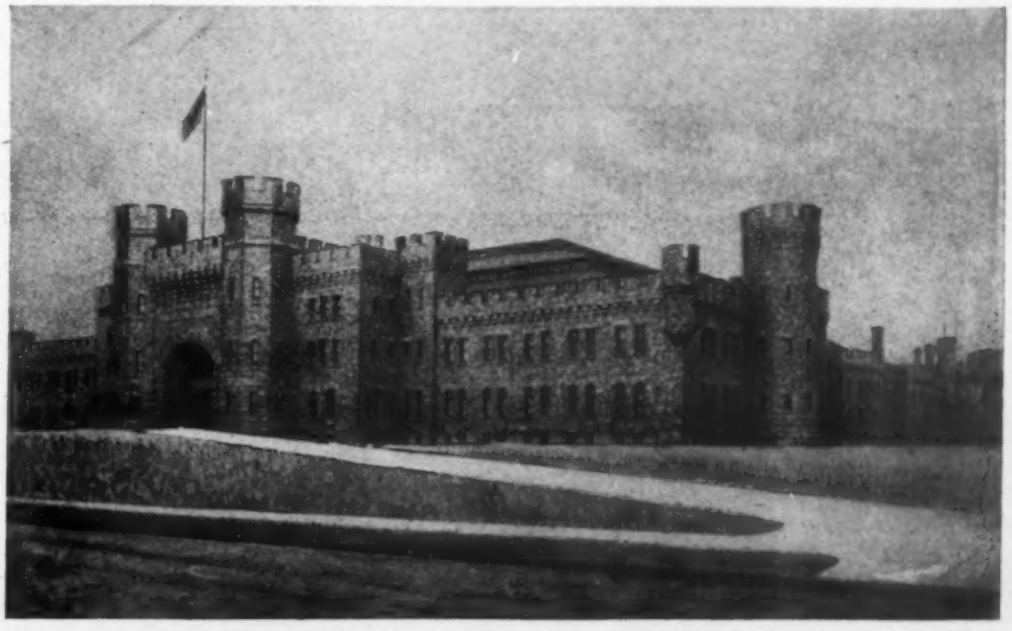
It is not my purpose to try to tell trustees which of these methods of financing their institutions they should follow, or to suggest how much protection should be attempted in the way of endowment, and how much reliance should be placed upon each year and each generation to bear its part of the financial burden. My purpose is fulfilled in emphasizing that endowments in funds are of value only as they guarantee that enrichment of the community for which hospitals are created. This is in a sense, I realize, a platitude. Yet it is that kind of truism which possibly should be brought up periodically for fresh recognition.

The true wealth which comes to a community from a hospital consists in the adequate care for the sick, the influence generally on medical standards and public health, the advance by research in the sciences of medicine and hygiene, the high and broad educational facilities for nurses and medical students.

In hospitals, and generally in health and educational agencies, especially apt is that scripture which declares that they who save their lives shall lose them and that only they that lose their lives in a cause really find them.

BUFFALO CHOSEN FOR 1924 CONFERENCE

The 106th Armory, Buffalo, N. Y., illustrated below, has been chosen as the place of meeting of the twenty-sixth annual conference of the American Hospital Association to be held the week beginning October 6, 1924. This decision was reached at the last meeting of the trustees of the association, January 15, 1924.



The 106th Armory, Buffalo, N. Y.,, where the 1924 conference of the American Hospital Association will be held.

DECREASING THE VOLUME OF CASE RECORDS

By ZULA MORRIS, Record Librarian, Butterworth Hospital, Grand Rapids, Mich.

DURING the last decade one of the big problems in hospital administration has been the securing of complete and accurate case records. This ideal has by no means been universally, nor even generally, attained. To this fact the incoherent and illogical histories which the files of even our best hospitals must occasionally exhibit bear indisputable testimony. But the working out of this standard and the accumulation of much material has given rise to a new problem which bids fair to overshadow the original one. This problem is the final disposition of records. Thoughtful persons everywhere are beginning to ask themselves: "By what means can we decrease the volume of our records?"

Of course, sooner or later, the question, "How long shall we preserve records?" will have to be faced squarely. Nobody can contemplate the rapid accumulation of volumes (or of filing cabinets for unbound records), even in a small hospital, without realizing that eventually a time limit for preservation of case histories will have to be set. However, this is not to be determined entirely by hospital administrators—the decision will no doubt be largely influenced by the medico-legal and scientific aspects of the question. How long case records have legal value and how long they will prove useful for research work is a two-sided question to be settled by reference to court decisions and opinions of the medical profession.

Volume of Paper Needs Diminishing

Pending such a settlement of the question by fixing an arbitrary date limit for the preservation of case histories, hospital superintendents everywhere are considering methods of conserving space in the handling of records. The number of cubic feet of space required to house records ten years—or five years—from now, if there should be no lessening of bulk, appalls them. The inevitable and unanimous conclusion is that the volume of paper devoted to case records must somehow be diminished.

Several suggestions toward this end have been made. One of the first was that both sides of each sheet used in compiling a history be utilized. Because of the form of chart holder most commonly employed, this suggestion has not been deemed practicable. With this holder, opening from the end instead of the side of the sheet, writing on the back of a sheet has been found inconvenient. Also, with such a disposition of notes on the sheet and the usual arrangement of sheets in the holder, examination of nurses' notes by physicians is a cumbersome and time-wasting process.

Another device for reducing the bulk of records is having the entire history, exclusive of nurses' notes, typewritten. This is usually accomplished by transcription from a dictating machine. It is effectual for the purpose designed, but not at all economical because of the time required. Under the operation of such a system, the record librarian keeps a progress sheet for each hospital resident and adds to these notes daily, or as often as physicians dictate their findings. Only the person who has kept these sheets, who has daily abstracted them from the files, who has daily transcribed from the dictaphone from fifty to one hundred notes, and who has then reinserted these progress sheets in the files can realize how much time is thus consumed. In fact, in an ordinary 100-bed hospital, the time required for such a series of mechanical actions is so great that the process cannot be carried through unless a typist is employed in addition to the regular record librarian. And it does not meet the situation adequately in that it in no wise affects the most voluminous part of the record,—that is, the nurses' notes.

Advocates Discarding Nurses' Notes

The objections to the above-named methods of shortening the record make these methods non-feasible. But they do not apply to a third plan, the one which it is the aim of this article to propose. This plan looks toward the discarding of nurses' notes in their entirety. These notes are usually couched in a form that is verbose, vague and unscientific, and the really pertinent information they contain could be expressed much more briefly and lucidly. Quite clearly the only person capable of condensing these inarticulate nurses' notes into concise phraseology and scientific terminology is the attending physician. If he would make daily progress notes, using the nurses' notes with their basic facts merely for guidance in stating patient's condition at twenty-four-hour (or shorter) intervals, there would be no necessity for preserving nurses' notes. The cubic contents of the record to be filed would be vastly cut down and the perplexing condition would be provided for,—at least partially. It would be possible then to care for all records till such time as the question of how long records should be preserved can be settled.

Better Progress Notes Needed

It would seem that the best solution of the vexed problem of so reducing our records that we shall be able to find a place to keep them is to require better progress notes from our physicians,—progress notes which shall incorporate all the valuable information to be gleaned from the nurses' notes and supplement this with the physician's own observations. Such notes would require from five to ten minutes daily of the physician's time, but they would put significance into the progress record. They would interpret the concrete facts of the nurses' notes in a scientific manner and would render these notes superfluous. That is, superfluous for purposes of filing. They would be indispensable to the physician as affording him a concrete basis for his scientific deductions regarding the course of the disease.

For some time the question here discussed has been under consideration by the Grand Rapids Association of Record Librarians, an organization formed for the purpose of cooperation between the record departments of the three largest hospitals of the city and discussion of their common problems. This association would be glad to have from any interested readers of The Modern Hospital criticism of the plan here advanced and suggestions as to other ways of solving this very real (and soon to be pressing) difficulty of decreasing the volume of case records. If the problem has somewhere been settled satisfactorily, perhaps the originator of the successful scheme will give readers of the magazine the benefit of a detailed account of its operation. We invite criticism of our plan and information as to the plans of others.

Self-love, my liege, is not so vile a sin
As self-neglecting.

—Shakespeare.

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Hospital Not Liable for Accidents of Employees

The Supreme Judicial Court of Massachusetts recently made a decision on a point of negligence. The plaintiffs, it seems, were walking on the sidewalk, when the hospital ambulance ran over the curbing and struck them. Negligence and misconduct were charged and, among other defenses, it was stated that the defendant hospital was a public charitable corporation and thus not liable.

The ambulance belonged to the hospital and was operated by an employee and, at the time of the accident, was in use on hospital business. It was admitted that the plaintiffs were careful and that the employee was negligent. The only question raised was whether the defendant was exempt from liability.

The court points out that the immunity of hospitals from the negligence of servants rests on the theory "that the funds of a public hospital are devoted to a charitable trust and that to subject them to the payment for negligence of its servants would be an unlawful diversion of the trust." In the opinion of the courts, this non-liability extends both to incompetent subordinates and subordinates selected with care.

The question is raised that the injury in this instance was not to a patient but to a stranger, which distinction apparently is not recognized under the Massachusetts doctrine. The court is unambiguous in its statement that "these trust funds cannot be used to compensate wrongs committed by agents of those administering the funds, and that there is no ground for distinction between liability to a patient and liability to a stranger. If, as a matter of public policy, there now should be a modification of the law in this commonwealth exempting charitable organizations from liability for the negligence of servants, such change must be made by the legislature." *Foley vs. Werson Memorial Hospital 141 N E 113.*

Not Liable for Default of Persons

The following situation involves the negligence and liability of the county, as decided recently by the Supreme Court of New Hampshire. The plaintiff, while confined in the Rockingham County Workhouse, was put to work by one of the commissioners on a hospital which the county was building. While thus employed he was seriously injured as the result of the unsafe staging provided.

A number of points which involve the county as a branch of the government can only be mentioned. For example, each county is a body corporate for the purpose of suing and being sued, performing the functions conferred by statute. It is a territorial division of the state created for the more convenient exercise of government. Its powers are generally purely governmental and consequently in "the absence of a statute imposing liability is generally conceded to be not liable to persons injured by their neglect of duty."

It is agreed that a municipal corporation "is not liable in an action of tort to a person injured by its negligence in the performance of a public governmental duty imposed upon it by statute, or by the negligence of persons nominally the officers while acting, not as servants or agents of the municipality, but as independent officers." So far as the performance of the governmental duty is concerned, the position of the county is the same.

It was argued among other things, that "the plaintiff's right as a convict was a public right. The plaintiff contended that it was superseded when he was accepted on the work as a laborer by his private right to reasonable conduct from those with whom he came in contact, and he argued that he has an equal right to recover for an invasion of his private right of safety as for an invasion of his private right of property by being engaged in the performance of a publicly imposed duty."

The court stated "that the county or any other municipal organization is not liable for default of persons, nominally its officers, who are acting as public officers and not as its servants or agents, is a proposition which is beyond dispute. Although the case states the insufficient staging was due to the negligence of the county, the evidence upon which the finding was made, is not reported. In the absence of information as to the facts and rules of law upon which the staging was found unsafe through the negligence of the county, the conclusion may properly be disregarded. The county could have had nothing to do with the erection of buildings. The county convention could authorize their erection, but the building could be erected only by the commissioners. As the county had no authority to erect the building, it is not liable for an insufficient staging used in its erection."

The only question which seems to have been presented to the court for argument was the matter of the liability of the county. The court did not decide that the claim, if well founded, could or could not be prosecuted by suit. The only New Hampshire law creating a liability for the county in default of the performance of duty relates to liability for debt or damages "in case of the escape of any debtor through the insufficiency of the prison." *O'Brien v. Rockingham County 120 Atl. 255.*

Exempt From Negligence of Employed

A charitable municipal hospital is not liable for the negligence of its employees, even where fees are paid by the patient, according to a recent holding of the Supreme Court of Tennessee.

The plaintiff was taken to the hospital to be operated on for appendicitis, as a pay case. After this the patient was returned to her bed in which her attendant physician saw a hot water bottle. The next morning she claimed that her heels were burned. On examination, it was shown that the entire heel was involved. She was removed from the hospital in about a week, but the burns were treated for four months, during which time she was unable to walk or stand on her feet. The injury, in the opinion of her physician, was permanent as the heel was devoid of cushion or ball.

The court holds that the consensus of authoritative opinion supports the doctrine that a charitable municipal hospital is exempt from liability for an employee's negligence, whether or not fees are paid.

The evidence as to who placed the hot water bottle is not conclusive and responsibility was not determined. *Wallwork vs. City of Nashville 251 S W 775.*

And he that will this health deny
Down among the dead men let him lie.

—Dyer.

The strongest principle of growth lies in human choice. —George Eliot.

A STORY OF THE DEVELOPMENT OF THE MAGAW MEMORIAL HOSPITAL, FOOCHOW, CHINA

By CORA E. SIMPSON, R.N., Executive General Secretary, Nurses' Association of China, Shanghai.

WHEN I arrived in Foochow, China, to establish a nurses' training school I found an old mud building being used for a hospital with patients camping in it in order to study foreign medicine. There was no medical school, no nurses, no text books, no nurses' association, and no ward for trained nurses.

Foochow is the capital city of Tuhkien Province in South China, and is one of the port cities opened by treaty many years ago. It has a population of over a million, is one of the old walled cities located near the old Ming river, thirty miles from the open sea, and is almost surrounded by the Kuliang mountains.

It is the political, social and educational center of all this part of China. Like most places in China, sanitation is unknown, nursing is in its infancy and medical science is yet undeveloped.

Plenty of sickness? Yes! The need and suffering there made one sick at heart. Mothers were constantly dying alone unassisted in child-birth, and infant lives were being lost by the thousands every year with no one to care. All the diseases known to mankind and many yet undiagnosed—cholera, plague, smallpox and leprosy—were with us all the time, sometimes sweeping off thousands within a few weeks. These together with ignorance, poverty, and superstition made it a most inviting field in which to spend one's life.

Magaw Memorial Hospital staff nurses and doctors.

I will not tell you of the years of teaching, working, hoping, praying until now. We have a National Nurses' Association of China. Our nurses' training school established in 1907 was the first school registered. Our first nurse was graduated in 1909. She was an unusually bright girl and had helped in the hospital for some years before this and has since studied medicine. We now have a national ward for the trained nurse and plenty of text books translated. Over thirty nurses have been graduated and are now out in needy places in China as head nurses in other hospitals, as school nurses, as district nurses, and many are in homes of their own away in the inland places where they are the only person with any medical knowledge for a day's travel in any direction. We have about twenty-five nurses in training and others are eagerly demanding entrance to be trained. After our nurses are graduated, we give them one year in midwifery and medicine so that they are most practically fitted to serve China.

In place of the old mud buildings we now have a new modernly-equipped brick building known as the Magaw Memorial Hospital. It contains operating, delivery, microscopic and X-Ray departments with adequate facilities at the disposal of the white-robed Chinese nurses who minister to patients day after day. Last year we had about 1,000 in-patients and the number will run higher every year, while our outpatient department handles fifteen times that many every year.

Our clinical nurses and doctors are daily called into homes near and far and carry Western medicine far into the mountains on these dispensing trips. We have now a good medical college and train our own Chinese physicians. We also have an intensive work among the lepers. The leper colony is located five miles from the hospital, outside the city walls at the foot of the mountains.

Almost 1,000 lepers have their last homes here. We have provided them with a chapel, a home, a school, and teachers as well as nurses and doctors who heal and comfort them with the hope of a life beyond the grave. You who know anything of the loathesomeness of this disease will realize what this ministry to these outcast, despised ones must mean. They would gladly kiss the shadow as we pass, such is their appreciation of our help.

Perspective, Magow Memorial Hospital. Group of nurses starting out for district work.

Nurses are about to inoculate these school children against plague and cholera.

Last summer during the terrible cholera epidemic our hospital was used as the American Red Cross Cholera Hospital for women and children. Our nurses all volunteered their service for their own people at a time when all the foreigners and many Chinese had left the heat and dust of the plague-infested city and were safe on the hills of Kuliang.

This is only the realization of a dream of one American girl. I have dreams of the Isolation Hospital rebuilt, of another story added to the hospital to provide nurses' home, of a chapel and out-patients' department, of a hospital dispensary for the leper people, and last of all my dream for the nurses.

While in the states in 1917, I had the great privilege of taking the National Public Health Course and as a result, I am most solicitous for the success of a number of Chinese nurses who are now doing public health, child welfare, infant hygiene, home nursing work, and are teaching sanitation to these needy mothers in the city.

Ten years from now I plan to tell you of other achievements which I hope will be realized.

FOLLOW-UP SERVICE OF LANKENAU HOSPITAL BRINGS RETURNS

By Annie M. Jastrow, Director, The Lankenau Hospital Follow-Up Service, Philadelphia, Pa.

A NUMBER of original features distinguish the follow-up system of Lankenau Hospital, although it is based upon similar systems in use at other hospitals in the country. It was established in October, 1920.

On admission the patients are sent to the wards or private rooms as the case may be, with their bedside charts on which the register number of the patient is stamped; on discharge the date for his first return visit is written on the chart by the head nurse or one of her assistants. The office on each station is provided with a schedule, prepared in the office of the follow-up department, indicating the approximate return date for the various diseases and conditions. For unusual cases, which are not included in the schedule, the head nurse refers to one of the chiefs or to the house doctor as to the desirable time for the patient to return for observation. Minor ailments, either medical or surgical, are not followed up.

Multiple Card System

When ready to be discharged each patient receives a card (about three by five inches in size), different colors serving to indicate the different services: yellow for surgical, blue for medical cases, etc. On the face of this card appear the patient's register number, his name, address and date of first return appointment. At his first and at all subsequent visits, he presents this card and, after an interview, the card is handed back to him with the next return date written on the reverse side.

Private patients receive a white card (visiting card size) which also contains the register number, service, name, address and date of first appointment. After the interview in the follow-up clinic, these patients receive a new card with the date of the next appointment. It is an interesting fact that the co-operation of private patients has been, if anything, more satisfactory and encouraging than of ward patients, a circumstance which contrasts most favorably with the experience of other hospitals. Indeed, many hospitals make no attempt to include their private patients in their follow-up work.

The follow-up service at the Lankenau Hospital occupies separate quarters where all the work of the department is done and where the follow-up records are filed. The personnel consists of a director, an office assistant, and a social worker.

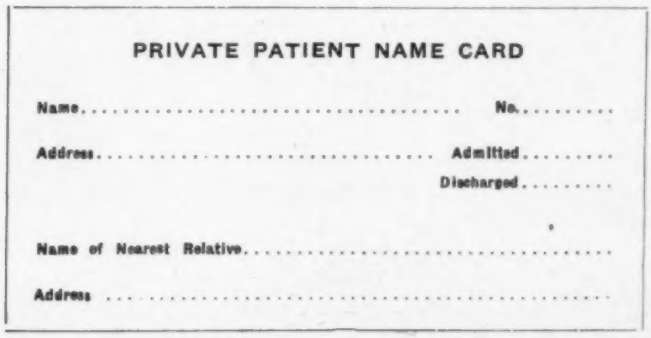
The director should be some one familiar, not only with medical terminology, but should have a general knowledge of medical and surgical procedure and some idea of diagnosis and prognosis in the particular type of case with which the hospital deals.

The files of the department consist of name, calendar, number, diagnosis files; summary and follow-up sheets, questionnaire, social service, hold and closed case files.

The name card contains the usual social information regarding the patient, and other items such as register number, service, diagnosis, operation, referring physician, and the first return date.

The calendar card contains on the face, the number, name and address of the patient and of his nearest relative, dates of admission, and discharge, diagnosis and operation. On the reverse side, this card is arranged in quadrille ruling with the names of the months down the left side of the card and the days of the months across the top; the dates are marked by a stroke (/) in the appropriate square.

The diagnosis file is arranged with cross references for the various diseases. Each diagnosis card (buff in


PRIVATE PATIENT NAME CARD

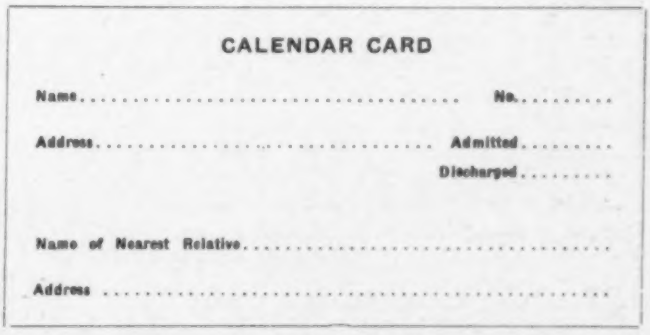
Name..... No.....

Address..... Admitted.....

Discharged.....

Name of Nearest Relative.....

Address .....


CALENDAR CARD

Name..... No.....

Address..... Admitted.....

Discharged.....

Name of Nearest Relative.....

Address .....

Name cards are kept for every patient, blue for private and tan for ward patients. Similar calendar cards are kept for ready information of admission and discharge.

color) is followed by a (blue) card for the accompanying condition or conditions. The cross reference cards are similarly arranged.

The operation file is also a cross-reference file with cards of different colors for the condition for which the operation was done and for accompanying operations.

As the patient is discharged, or as soon after as possible, the complete history, together with all laboratory reports, x-ray findings, operation or treatment, is sent to the follow-up office, where a brief abstract is made on the *summary sheet* which is filed by number.

The summary sheet contains the same information as appears on the name card. Below this follows the abstract (as above mentioned) of treatment, operation, post-operative course; the morbid anatomy, the condition on discharge, disposition of the case and the first follow-up date.

Patients returning to the clinics are examined by regularly appointed members of the hospital staff assisted by the interns and with the visiting chiefs in consultation when necessary. Surgical clinics are held twice a week, and medical, eye, ear, nose, and throat clinics once a week.

The results of the examination are written out by the examining physician and are copied in typewriting on the *follow-up sheet* which is filed with the summary sheet and held for future reference. In this way a continuous record of the patient is kept until he is dismissed from the follow-up service. The sheets are kept on file in the follow-up office and are available in case the patient should return to the hospital at some future time. A case is considered closed only with the death of the patient, in which event the summary and the follow-up sheets are pasted in with the original history in the bound volume which is kept in the record room of the hospital.

The results of the follow-up examination are also noted in the diagnosis file according to the number of months elapsing since operation or treatment. The patients receive a rating according to their presenting condition; A, indicating the anatomic result, that is, the condition of the wound; S, symptomatic result, and E, the economic condition (working capacity) of the patient; the rating being from 0, the lowest, to 4, the highest figure. For example: patient No. 293/21 has been operated upon for chronic cholecystitis associated with chronic appendicitis. He returns to the follow-up clinic four months after operation. The wound has healed perfectly, he is relieved of the symptoms for which he came to the hospital, but has not yet regained his former strength or normal working capacity. This patient would receive a rating:

A. S. E.
4 4 3.
4 4 3

In the diagnosis file, following the cards: "chronic cholecystitis, accompany condition, chronic appendicitis," there will be a lead "Four Months," and the case will be entered on the card: Chronic cholecystitis, 1921,—293 (443); and similarly under chronic appendicitis accompanied by chronic cholecystitis; all similar combinations of diseases and time after operation will appear on this same card.

If the examining physician finds it necessary to see the patient again, he assigns a return date, which he notes

LANKENAU HOSPITAL OF PHILADELPHIA
FOLLOW-UP SHEET

NAME.....AGE..... NO.....

ADDRESS..... SERVICE.....

Operation Date of Operation
Date of Discharge

Interval after operation.....months Examiner

Diagnoses { Add new diagnoses / after old diagnoses } Results: A. S. E. Return Date

PRIVATE PATIENTS

NAME..... NO.....

ADDRESS..... .....SERVICE

APPOINTMENT .....AT....O'CLOCK

LANKENAU HOSPITAL
CORINTHIAN AND GIRARD AVES.
PHILADELPHIA.

FOLLOW-UP SERVICE.

Card given to private patients to facilitate the keeping of appointments.

NAME CARD

No.....
Name..... Service.....
Address..... Age.....
Color..... Nativity..... Religion..... Occupation.....
Admitted..... Discharged..... Result.....
Diagnosis .....

Relative..... Address.....
Referred by Dr..... Address.....
Follow up Date..... Interne Dr.....

LANKENAU HOSPITAL

SURGICAL

Name..... No.....

Please come to the Follow-up Clinic,

on..... *at*.....

so that we may know how you are getting on.

If you change your address, please send new address to

LANKENAU HOSPITAL
Corinthian and Girard Avenues, Philadelphia

THERE WILL BE NO CHARGE FOR THIS SERVICE

ALWAYS BRING THIS CARD

The card on the left is the name card for ward patients. Cards are also given patients to help them remember follow-up work. The card on the right is that given to a surgical patient. Similar cards are given to patients in other departments; blue for medical, green for eye, and brown for nose and throat patients.

on his examination slip and also on the patient's card. This date is then recorded on the follow-up sheet and on the calendar card. Patients who are not doing well or whose operative results are not satisfactory are referred to the chiefs for examination.

The date on which the patient is to return, having been marked in the proper square on the back of the calendar card with an oblique stroke (half the letter X), this stroke is completed if the patient has come back, and the next date again marked with a similar stroke. One card can easily serve for several years by writing in the year in small figures above the stroke.

THE LANKENAU HOSPITAL

FOLLOW-UP SERVICE
Corinthian and Girard Avenues
PHILADELPHIA

Please do not forget your appointment at the Lankenau Hospital on ..... at twelve-thirty o'clock.

Kindly let us see you or hear from you and oblige

(Miss) .....Direct.
The Lankenau Hospital
Follow-Up Service

Card used for private patients' reminder.

In case the patient does not return on the appointed date, the stroke is placed for a week later, as he may possibly send word as to his reason for not coming in. After this the square on the calendar card is marked with a small *s* to indicate that the social worker has been sent out to investigate the reason for his failure to come back.

The social worker keeps a file with the reports of the results of her visits. For out-of-town patients who fail to return, a small letter *l* next to the date in the square indicates that a form letter explaining the value of the follow-up service to himself and to future patients urging him, if possible, to

Dear .....

Since you cannot come to the hospital for examination, will you kindly co-operate by answering the following questions or, if possible, have your family physician do so, and return same to

The Lankenau Hospital
Follow-Up Service

Are you free from the complaint for which you were treated?..
Do you still have the same complaint?.....
Have you any other complaints?.....
Have you had any other treatment?.....
Of what did it consist?.....
What is your usual weight?.....
What do you weigh now?.....
Are you as strong as you were?.....
How soon were you able to return to your work?.....
Is your earning capacity normal?.....
If not, how much below normal is it?.....
Are your bowels regular with medicine?.....
Are your bowels regular without medicine?.....

Dear .....

Since you cannot come to the hospital for examination, will you kindly co-operate by answering the following questions, or, if possible, have your family physician do so, and return the same to

The Lankenau Hospital
Follow-Up Service

Are you free from the complaint for which the operation was done? .....
Do you still have the same complaint?.....
Have you any other complaints?.....
Have you had any other operation or treatment?.....
Of what did it consist?.....
Was your wound healed when you left the hospital?.....
If not, how soon did it heal?.....
Are you satisfied with the results of the operation?.....
What is your usual weight?.....
What do you weigh now?.....
Are you as strong as you were?.....
How soon were you able to return to your work?.....
Is your earning capacity normal?.....
If not, how much below normal is it?.....
Are your bowels regular with medicine?.....
Are your bowels regular without medicine?.....

Dear .....

You may remember when you left the hospital on .... the privilege was asked of seeing you at a future date, and a card was given to you to that effect. Since the results of treatment differ in different individuals, what may be learned from the effects of the treatment in your case may be of value in treating similar cases in the future.

Will you therefore kindly co-operate by coming to the hospital for examination on ..... at ..... o'clock, p. m., bringing your card with you.

Very truly yours,

The Lankenau Hospital
Follow-Up Service

(Miss) .....Direct.

Dear Doctor:—

Your patient ..... whom you kindly referred to this hospital, was discharged on .... in ..... condition. Study and operation of the case proved it to be..... .....

In order to ascertain the ultimate effects of the operation and treatment, the privilege is requested of having ..... return from time to time, not for treatment or advice, but for observation only. For this purpose ..... has been asked to come to the hospital on.....

It would be a pleasure if you could find it convenient to be present at that time. If you will signify your desire to be here, you will be notified several days in advance of the date set.

Very truly yours,

The Lankenau Hospital
Follow-Up Service

(Miss) .....Direct.

Dear Doctor:—

Your patient ..... whom you kindly referred to this hospital, was discharged on .... in ..... condition, after having received treatment for ....

In order to ascertain the ultimate effects of the treatment the privilege is requested of having ..... return from time to time for observation. For this purpose ..... has been asked to come to the hospital on..... .....

It would be a pleasure to have you present at that time, and if you will signify your desire to be here, you will be notified several days in advance of the day set.

Very truly yours,

The Lankenau Hospital
Follow-Up Service

(Miss) .....Direct.

Dear .....

When we last heard from you we noted that you were .... free from the symptoms for which the operation was done. Will you kindly let us know whether or not your condition is the same?

If there is any change kindly answer the following questions, or, if possible, have your family physician do so. In any case please reply as promptly as possible to

The Lankenau Hospital
Follow-Up Service

Are you free from the complaint for which the operation was done? .....
Do you still have the same complaint?.....
Have you any other complaints?.....
Have you had any other operation or treatment?.....
Of what did it consist?.....
What is the present condition of your incision?.....
Is it entirely healed?.....
What is your usual weight?.....
What do you weigh now?.....
Are you as strong as you were?.....
How soon were you able to return to your work?.....
Is your earning capacity normal?.....
If not, how much below normal is it?.....
Are your bowels regular with medicine?.....
Are your bowels regular without medicine?.....

The system of follow-up letters is carefully worked out: (upper left) letter sent to medical patients after discharge; (center left) similar letter sent to surgical patients; (lower left) letter sent to private patients when they fail to return to the clinic on the first assigned date; (upper right) letter sent to doctor referring surgical case; (center right) letter sent to doctor referring medical case; (lower right) second follow-up questionnaire sent to surgical patients.

LANKENAU HOSPITAL OF PHILADELPHIA
SUMMARY SHEET

No. .....
Service .....
Ward .....

Name .....
Address .....
Single or Married.....
Birthplace..... Age.....
Religion .....
Occupation .....
Relative .....
Address .....
Admitted..... Discharged.....
Referred by Dr.....

Fre-Operative .....
Diagnosis .....
Operative .....
.....
Operation .....
.....
.....
.....
..... Result.....

Summary of History, Chief Complaint, Signs and Symptoms on admission.

Clinical Pathology.

X-Ray Opinion.

Summary of Treatment and Course in Hospital. Specify Complications.

Morbid Anatomy.

Summary of Symptoms, local and general on discharge. Compare with those on admission.

Follow-up Date.

.....Intern in charge of case.

return at a convenient time, has been sent out. A similar form letter is also sent to private patients who fail to keep their appointments. If having the social worker does not succeed in bringing the patient back or in getting the desired information, or in the case of an out-of-town patient or a private patient, the letter failing of its object, a questionnaire is sent to the respective patient to be filled out by him or by his physician. Private patients living in the city can usually be communicated with by telephone or by form letter, as above.

The questionnaire file is kept for the purpose of tracing patients in one or another of the above classes.

Deaths occurring in the hospital are marked on the diagnosis and on the operation card with one red asterisk; deaths subsequent to discharge are noted with two red asterisks on the diagnosis card, according to the number of months elapsing since discharge from the hospital. The date of death is also marked on the name card of the patient in the name file, and on the calendar card, which is then placed in the closed file.

It is the policy of the follow-up service of the Lankenau Hospital not to interfere in any way with the relation of the patient and the physician referring him to the hospital. The physician is informed (by form letter) of the steps taken by the hospital to have the patient come back at a certain date, and at the same time is invited to be present at the examination if he so desires. Any treatment or suggestion as to treatment is carefully avoided. Very often patients returning to the follow-up clinic have not been under the immediate care of a doctor. In such instances, if in the judgment of the examining physician the patient's condition indicates the desirability of a certain regime or treatment he is advsed to return to his doctor and the latter is informed of the findings of the follow-up clinic.

The cooperation of referring physicians has been most encouraging.

In the three years of its existence, the follow-up service of the Lankenau Hospital had the gratifying return to the clinic of 73.7 per cent (or 6,918 of the 9,387) of the patients expected, while 17.1 per cent were followed by questionnaire or letter, making a total of 90.8 per cent of patients traced.

The value of a follow-up surgical and medical hospital service is in direct proportion (1) to the benefits it extends to hospital patients, and (2) to the importance which the data collected by the department may have in fulfilling that wider scope of hospital function in contributing to the improvement in methods of treatment and to the advancement of the science of medicine.

That the patients of the Lankenau Hospital appreciate the benefits of post-hospital observation is manifest by the eminently satisfactory percentage of individuals who returned for examination. By far the greater majority of them came back, not because they needed further attention, but because, realizing the value of the service, they were imbued with the earnest desire to cooperate in order, as many of them express it, "possibly to help the next patient."

Among the outstanding advantages to patients are the results of interval observation in malignant disease, particularly of the breast. Very often, owing to ignorance or to lack of means, these patients are not under the direct care of a physician, and therefore fail to continue x-ray or other treatment so essential for their continued well-being. If the suggestion offered by the follow-up service, and acted upon the patient in this type of case alone, delays or perhaps prevents recurrence, or merely prolongs life and makes it bearable in only a certain percentage of cases—this alone would justify its existence.

The scientific value of follow-up records is obvious. In view of the large personal element entering into the results of treatment, it is only upon the evidence gathered from a great number of cases that one may venture to draw conclusions. While no exhaustive study of any one subject has as yet been undertaken, there are certain types of cases in which the observations are of interest and perhaps of value as, for example, observations of patients who have had a gastro-enterostomy performed for gastric or duodenal ulcer. Each one of this class of patients who comes to the follow-up clinic is sent to the x-ray department for fluoroscopic examination. It is a generally accepted belief that when the pylorus is not obstructed and a gastro-enterostomy opening is made, nearly all the food will pass through the normal pyloric opening and that none of it will go through the new channel. We have found that this is by no means an invariable rule. Very often, even where there was no operative procedure obstructing the pylorus, the food passes out of the stomach through the new stoma.

Another interesting observation has been made with regard to the spontaneous closure of the gastro-enterostomy in the presence of a patulous pylorus. Our observations show that in the same patient at one examination the gastro-enterostomy opening had apparently closed, but at a subsequent observation it was again open. This makes evident the necessity of repeated examinations after gastro-enterostomy in order to determine the status of gastric function after the operation. It is proposed to make a study of the possible relationship of these facts, namely gastro-enterostomy and a patent pylorus, and the recurrence of ulcer symptoms observed in from five to six per cent of patients returning for observation.

HOSPITAL NUMBER OF A. M. A. JOURNAL PRESENTS STATISTICAL SURVEY

AN ABUNDANCE of statistical facts concerning the hospitals of this country is contained in the annual hospital number of *The Journal of the American Medical Association*, January 12, 1924. Our readers are doubtless familiar with many of the general facts concerning hospitals of the United States but some facts concerning special types of hospitals may prove interesting and valuable.

It is of interest that in the survey of county hospitals it was found that only 361 out of 3,066 counties maintain hospitals and that these 361 counties support altogether 465 hospitals with a total capacity of 46,571 beds. California leads in the number of county hospitals, having fifty-six, while New York ranks second, with fifty. Georgia, Louisiana, Mississippi, and Rhode Island have no county hospitals, although the lack of such hospitals does not, in all instances, mean that these states are entirely without county hospital service. Including private hospitals of the 3,066 counties, 1,521 or 49.6 per cent have at least one hospital. This shows an increase of 5.6 per cent of the report of 1920 when only 1,332 or 44 per cent of the counties were supplied with hospitals.

Thirty-five hospitals having a total bed capacity of 4,701 beds are maintained jointly by city and county. This arrangement of city and county in supporting a hospital has been found expedient where the city and county nearly coincides as to area and population and often means that the hospital is thus afforded better facilities than could be supplied to two separate institutions.

The report shows that there is a decided tendency towards increase in the number of special hospitals and provision for special types of cases in general hospitals. This tendency is noticeable in the number of hospitals which are setting aside wards or buildings for tuberculosis, isolation, venereal, and nervous and mental cases.

In the survey of institutions related to hospitals, the report states that sanatoriums and other institutions devoted exclusively to the care of the sick, and hospital departments of related institutions including homes, schools, orphanages, reformatories, etc., where inmates are cared for when sick, are included. On this basis the report includes 906 such institutions of which 767 have hospital departments with an aggregate capacity of 24,926.

Lack of Laboratories Appalling

A part of the report of particular interest is that pertaining to laboratories and nurse training schools. A table is given showing the number of hospitals having laboratories, roentgen-ray departments and nurse training schools. Although there has been remarkable progress in the development of hospital laboratories it is surprising to find that out of 2,731 hospitals of twenty-five beds or less only 710 or twenty-six per cent claim to have clinical laboratories. More significant is the fact that of the 2,704 hospitals of twenty-five to 100 beds only 1,366 or barely over fifty per cent even claim to have laboratories. Out of the entire group of 6,830 hospitals only 3,035 or 44.4 per cent report that they have laboratories.

Few Roentgen-ray Departments

Still fewer hospitals have roentgen ray departments, for out of 6,830 hospitals, 2,841 or 41.5 per cent report such departments. Of the hospitals of twenty-five beds or less 672 or 24.6 per cent have such a department. Of the hospitals from twenty-five to 100 beds, 1,281 or 47.4 per cent and the hospitals having from 100 to 300 beds report 246 or 60.1 have such departments.

Over half of the nurse training schools of hospitals are in institutions of from twenty-five to 100 beds, for out of 1,964 schools 1,031 or 52.5 per cent are in hospitals of that class.

Number of Training Schools Small

Of the hospitals ranging from 100 to 300 beds only 25.2 have training schools. Hospitals over 300 beds report 177 or 9.0 per cent. This low figure is partly accounted for in that many of these hospitals are specialized types for nervous and insane or for tuberculous patients and cannot maintain training schools. From the statistics and tables presented in the report it is evident that a large per cent of hospitals secure their nursing force in other ways. According to available data, 1,586 of these training schools have been approved by state boards. This means that there are at present at least 378 training schools that are not accredited.

ONTARIO HOSPITAL ASSOCIATION RECASTS SCOPE OF ACTIVITY

Representatives of Ontario hospitals gathered together December, 1923 for the purpose of recasting the Ontario Hospitals Association. The reorganized association purposes to function in a much broader way and deal with matters pertaining to hospital administration in general, nursing education, dietetics, and other departments of the hospital.

About four years ago the hospitals of Ontario organized to meet certain urgent needs at that time, particularly the financial needs. The result of the organizing at that time was to increase the provincial and municipal per diem grants to the Ontario hospitals. Later the association applied for exemption of excise on alcohol purchased by all Canadian hospitals and this was granted. This exemption has resulted in a saving of many thousands of dollars to the Canadian hospitals. Last year the association placed application before the Dominion government for exemption for sales which, it is expected, will be granted soon.

The new officers of the association are: president, Colonel William Garthshore, London; first vice-president, Mrs. H. M. Bowman, Women's College Hospital, Toronto; second vice-president, Dr. Edward Ryan, Rockwood Hospital, Kingston; honorary secretary-treasurer, Dr. F. W. Routley, director of Red Cross, Toronto. The trustees are Dr. J. H. Holbrook, Mountain Sanatorium, Hamilton; Mr. E. R. Loughlin, St. Joseph's Hospital, London, Miss Elizabeth Whiting, Cornwall; Miss J. K. McArthur, Owen Sound; Mr. T. H. Pratt, Hamilton General Hospital; Major Moncrieff, Petrolia Hospital, Petrolia; Mr. James Govan, Inspector of Hospitals for Ontario, Toronto; Miss E. McPherson Dickson, Inspector of hospital training schools for Ontario, Toronto.

How much a dunce, that has been sent to roam,
Excels a dunce, that has been kept at home.

—Cowper.

THE INFORMATION DESK

No satisfactory solution to a problem in your hospital is too trivial to pass on to other workers in the field. No question that perplexes you is too small to bring to the attention of those with greater experience in the field. This department is the readers' exchange, and its usefulness is dependent upon the measure in which its readers share their problems and their discoveries.

DIRECT PAYMENT OF SPECIAL NURSES BY PRIVATE PATIENTS

One of our readers inquires as to the advisability of establishing a system whereby private patients would pay the special nurse directly. This system of direct payment of special nurses has been practiced by a number of New York hospitals. Although it has advantages such as relieving the hospital of the responsibility of pressing the patient to pay the nurse's salary, and the simplifying of bookkeeping, advantages of the system of payment through the hospital should not be overlooked.

Under the latter system the hospital has control of the nurses' charges, a guarantee against exorbitant rates which might be charged if the patient dealt directly with the nurses. The withdrawal of the hospital from direct relations with the nurse also increases the difficulty of control, for the hospital rules are less likely to be observed by nurses who are directly employed by the patients. It also means that the influence of the hospital in securing the use of special nurses in suitable cases is diminished and the opportunity is taken away to uphold professional standards by discrimination in the assignment of nurses.

From the legal aspect, the hospital which handles the payment of nurses' charges has the advantage, for, in general, the hospital is responsible for the exercise of due care in the choice of its nursing and medical personnel; it is just possible that the selection and payment of nurses by the patients themselves may relieve the hospital of a slight measure of responsibility in the case of a nurse's carelessness resulting in injury to a patient. The question of the employers' liability also needs consideration.

ELIMINATING ERRORS IN COUNTING LAUNDERED GOODS

Errors often occur in the checking up of laundered goods unless the hospital adheres to some accurate method of accounting for the same. The only safe way is to send the original lists or carbon copies to the laundry so that they can be checked in and out. In this way both sides check against each other and the mistakes consequently become less frequent.

The following method has proved a successful way of eliminating mistakes in counting. Have the goods put in units of ten or twenty and then count them. For instance, the towels should be put in lots of ten with each lot crossed so that it will show. The psychology of this is that the ordinary person becomes lost in counting a high number, and error results. Any person can be accurate in placing ten towels or other articles in a pile and likewise any person can be accurate in counting ten of the piles. Thus, one counts a hundred without becoming lost and if it runs into thousands the unit piles are counted in the same manner, and time is saved.

Goods should also be stored in the departments in units so there will be fewer mistakes in taking stock. If it is desired to make straight piles, each tenth sheet or towel can be pulled an inch forward, to show the unit.

ACCOUNTING FOR SMALL GIFTS

Hospitals, on the whole, do not pay enough attention to small donations other than cash. Very often small items of linen, clothing, food and reading matter are not accounted for and often, not even acknowledged. Many hospitals have a women's auxiliary which furnishes such items as linen which should not only be acknowledged but should be accounted for. The only equitable way by which this can be handled is to charge these items to operating expenses at market value and then credit as a corresponding income the donated amount equivalent to it. For instance, if the women's auxiliary or any other organization or individual donates to the institution ten dozen sheets, seventy-two by ninety-nine inches, the ten dozen are charged on the store linen and bedding account and as they are issued are charged the same as if they were bought on the open market. A corresponding entry should be made in the income account equivalent to the amount.

BASEMENT WALLS DISCOLORED BY PENETRATION OF MOISTURE

An inquiry has been made concerning what can be done to preserve basement walls which have become discolored through the penetration of moisture. When such a condition occurs there is nothing which can be done from the inside, as no paint will withstand moisture which has already penetrated through the surface of the paint.

The only remedy for this trouble is to dig out a part of the outer brick surface below ground level and apply a heavy coating of some water-proofing material such as tar. This method proves expensive but it thoroughly seals the wall which may then be painted with the paint used on the remainder of the interior. Unless immediate steps are taken to remove the cause of the trouble the discoloration will continue, regardless of what paint is applied, and a speedy disintegration of the paint film will result.

INFORMATION PAMPHLET ISSUED BY THE HENRY FORD HOSPITAL

INFORMATION

FOR PATIENTS

ENTERING

Henry Ford Hospital

INPATIENT SERVICE

Inasmuch as several times a day we are asked the question, "What articles should I bring with me when entering the hospital?," we have decided to print this little leaflet to give our patients the necessary information regarding that question, and additional information which may be of interest.

Henry Ford Hospital

DETROIT

POLICY:

The policy of the Henry Ford Hospital is to please every patient by rendering hospital service as nearly the ideal as possible and at a cost within the means of the average person.

WHAT TO BRING:

Patients entering the hospital should bring with them pajamas or nightgowns, negligee, bathrobe or kimona, slippers, extra stockings, comb and brush, toothbrush and toothpaste, manicure articles, and wash cloths.

If the patient entering the hospital is a man it might be well for him to bring necessary shaving articles in addition to the articles listed above. However, a barber calls daily on all male patients in the hospital and it is not, therefore, necessary to bring shaving articles.

WHAT NOT TO BRING:

Please do not bring unnecessary valuables with you, as the hospital is not responsible for valuables left in the patient's room should they be lost or stolen.

SAFETY DEPOSIT VAULT:

If you do bring valuables with you they may be deposited in our vault by application to the nurse on your floor.

WHAT THE HENRY FORD HOSPITAL FURNISHES IN THE WAY OF READING MATTER:

On each week day the Detroit Free Press is distributed to every patient in the morning, and either the Detroit News or the Detroit Times is distributed to every patient in the afternoon.

On Thursday of each week the Saturday Evening Post is distributed to every patient.

On Sunday morning every patient will receive either a Detroit Free Press, Detroit News, or Detroit Times.

All of these papers and magazines are distributed without charge to the patient.

The Henry Ford Hospital also maintains a library for the use of all patients. The Librarian will call at your door twice a week, or by special request, and will distribute books and magazines that may be of interest to you.

SMOKING:

We ask that patients of the hospital do not smoke on the premises. This request is made not that we have any fault to find with those who smoke, but because of the fact that with several hundred patients in the hospital we do not wish to encourage anything which will tend to increase our fire risk.

We have one of the most modern fireproof hospital buildings in the world, and it is doubtful if fire could gain any appreciable headway. However, as everyone knows, the greatest danger coming from a fire, even in a building where everyone is perfectly well, is the danger of panic. Everyone must realize that in a hospital with a number of people seriously ill, among them being post-operative cases, mothers of newly born babies, and newly born babies, the result of a panic would be nothing short of tragic.

We, therefore, ask our patients to take into consideration the well being of the other patients of the hospital and co-operate with us in carrying out this request.

VISITORS' HOURS:

Visiting hours at the Henry Ford Hospital for patients not in critical condition are from 1:30 to 5:00 and 6:00 to 8:30 p. m.

For patients in critical condition there are no special visiting hours, but relatives and friends may come at any time of the day or night. This ruling also applies to post-operative cases for a period of 48 hours from 8:00 a. m. the morning the operation is scheduled.

It is our desire to have visitors come to the hospital to see their relatives and friends only during the hours above scheduled. The reason for this is that there is a vast amount of routine hospital work that has to be done for all patients and the work cannot be done efficiently with the interruptions which would naturally come should we allow visitors to come at all hours of the day. We believe our visiting hours are as liberal as those of any other hospital in the country and with this in mind we feel that patients will co-operate with us in asking their friends to come only at the regular visiting hours.

Patients' rooms are in Units B, F, H, I, and M. Units B, F, H, and I are reached through the main entrance on West Grand Boulevard, and Unit M. is reached through the Hamilton Boulevard entrance. We ask all patients to advise their relatives and friends in which Unit they are located, and to ask them to use the Visitors' Entrances, as these entrances have been arranged in such a manner as to allow visitors to reach patients' rooms conveniently and with the least delay.

TIPPING:

For the information of patients entering the hospital, they are advised that we do not allow employees to receive tips of any kind. Employees of the Henry Ford Hospital are paid salaries above the average and there is no reason why they should receive additional small gifts to do the things they are employed to do.

The patients of this hospital are entitled to prompt, courteous and intelligent service. If every employee of the hospital does not render such service to every patient the management will appreciate being advised of this fact.

PHARMACY:

The hospital maintains a pharmacy in the lobby of the main building where hospital prescriptions may be filled, and in addition standard toilet articles are carried for the convenience of patients of the hospital.

VALET SERVICE:

Realizing that many patients often desire to have clothes pressed during their stay in the hospital we have provided proper facilities for that service.

TELEPHONE AND TELEGRAPH ROOM:

There is a telephone and telegraph room in the main lobby of the hospital.

INSPECTION OF THE HOSPITAL:

For your information, please be advised that it is our desire to have patients of the hospital and their friends inspect the hospital from one end to the other. We believe the Henry Ford Hospital is one of the finest hospitals in the world and we are anxious to have every person see it who so desires. Visitors who desire to inspect the hospital will please call at the Information Desk in the Main Lobby where a guide will be provided for this service.

ROOFING FOR THE SMALL HOSPITAL

Inquiries have been made concerning the types of roofs which are most practical for the small hospital. A paragraph from the article "Technical Data on Planning a Hospital and Selecting Its Fixed Equipment," by Mr. Meyer J. Sturm, Chicago architect, which appears in the fourth edition of THE MODERN HOSPITAL YEAR BOOK, page 73, will give general information on this subject. The following is given by the author:

"There are many types of roofs on the market, their number in fact is legion. Unless the roof on a building is the best obtainable, it is a constant source of trouble. If the roof is steep pitched either slate, tin, copper or tile should be used. Particularly careful preparation should be made for this work. As the menace of fire in smaller hospitals is as much from the exterior as from the interior some of the so-called fire resisting roofs should be used. For flat roofs, especially where the roof is to be used for promenade deck, it is well to put on a first class roof of asphalt or guaranteed tar products, and over this place a quarry tile or some other non-cracking and non-abrasive roofing material which would preserve not only the roof under it but would make it safe to use the roof for many purposes. Such tile should be laid in asphalt with expansion joints. The use of roofs for solarium and promenade purposes has become so universal as to require practically no mention here. However, if roofs are used in this manner, the walls about them should be of sufficient height to make them safe and still not so high as to shut off the view. A rail may be put up to make them safer. Parts of such roofs may be covered with light structures.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Dean, School of Nursing, College for Women,
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TEACHING PSYCHIATRIC NURSING

BY MAY KENNEDY, B.S., R.N., SUPERINTENDENT, ILLINOIS STATE SCHOOL OF PSYCHIATRIC NURSING, CHICAGO, ILL.

THE fundamental principles of the art of teaching are first a clear and definite idea of the subject; second, an exact and concise statement of the aim or purpose in teaching the particular subject; third, an intelligent organization of the course or courses which will accomplish our aims.

We may define our subject in very simple terms, by saying, psychiatry is that branch of medicine, which takes up the study of mental diseases and disorders. There is no better method of getting an accurate understanding of the term than to study its derivation. Psychiatry is not a new science. The Greeks and other ancient races were quite well informed on this subject. The word originated with the Greeks, and is made up of two words, *psyche*, meaning mind, and *jatreia*, the art of healing. The word healing implies to restore to soundness, to remedy. From the combination of these two words, we get a very intelligible and significant word, psychiatry. Psychiatry is therefore the science of restoring unbalanced minds to normal functions.

Side view of educational building, Illinois State School of Psychiatric Nursing, Chicago, Ill.

We will build our second principle on the definition of our subject and state our purpose in the following terms. The aims of our teaching are to prepare young women of character and education to nurse the mentally afflicted, to assist in the restoration of the unsound mind to soundness. Since we are living in the age of prophylaxis, a third factor calls for our attention, and that is a thorough preparation in mental hygiene, so that the nurse will be able to assist in the great mental prophylactic movements of the day.

The next step is to discuss the methods of accomplishing our aims. It is very obvious that if we reach the goal set for us, and if we prepare the nurses to meet the demands of the day, our course must be well organized and comprehensive. Instead of having one subject complete in itself, we have several different subjects, all to be mastered before we have sufficient knowledge to cope successfully with the original subject.

Study of Nervous System—Fundamental

The basis of psychiatry is the anatomy and physiology of the nervous system. The course in these subjects should deal in a special manner with the central nervous system. It is very necessary that this course be given well, because it is a prerequisite for the course in psychology and psychiatry.

Before we can understand the abnormalities of the mind, before we can intelligently appreciate unsoundness of mind, we must know something of its nature. Hundreds of eminent scholars, physicians, and psychiatrists have spent much time and energy in studying the mental mechanism of man. While advancement has been made, and we are proud of it, there is still much which baffles the learned. We have only begun to look upon this situation as worthy of scientific investigation. Because the mind is so intangible, because we cannot get into actual contact with it, it has been regarded by many as a most mysterious factor in man's makeup and viewed with more or less superstition. For this reason progress in the study of mental diseases has been slow.

The course in psychology should discuss the mental states, and the fundamental principles underlying human behavior, so that the student may become familiar with the well-known laws of psychology, and may be able to interpret the mental phenomena she is likely to encounter on the wards. The predominating thought in the course should be human behavior in its varying aspects. To understand and to aid in correcting abnormal conduct or behavior of people is the chief aim of the psychiatric nurse. To understand the abnormal, to correct the maladjustments which we find in society, the student must understand the normal. The course should

Recreation hour in the nurses' living room.

take up deflex and instinctive behavior first, because in the cycle of life that is our first level of conduct. Many of man's actions may be accounted for when our innate tendencies are understood. From these primitive forms of behavior we pass on to intelligent behavior, a higher level of conduct, depending upon the higher activities of the mind and brain.

Normal Behavior Needs Study

An eminent psychiatrist has said that the behavior of an insane person is only ordinary human behavior exaggerated, and when we study our psychiatric cases, we find that this statement is quite true. Since this is the case is it not possible to learn much about human conduct from the study of the abnormal, and may we not hope to gain knowledge from the study of the exaggerated behavior which may be used to the advantage of mankind? Some one has said that viewing the activities of the mentally afflicted is like viewing the normal activities of man under the microscope. If physicians and nurses would only take this attitude, much might be learned from actual contact with the insane.

Psychiatry does not treat merely of one disease. When we speak of nervous and mental diseases, we are speaking of twenty-two different psychoses, according to the classification adopted by the American Medico-Psychological Association. Over half of the psychoses of this classification have a further classification stating the different types of each special form, thus making over seventy-five different types of disease under the general term insanity or psychiatry. In the course in psychiatry an attempt should be made to acquaint the nurses with the broad classification and in a general way to touch upon the different types under the main topics. The etiology, symptoms, progress and treatment of the disorders are discussed. In connection with the formal lecture course, there should be clinics at which patients are presented, illustrating the different types discussed in the previous lesson. Attention should be called to the less prominent symptoms to be cared for. The treatment of particular symptoms is not taken up at any great length because that phase belongs to the subject of psychiatric nursing.

All the preceding subjects are the fundamentals for our next topic, psychiatric nursing. The nurse must be able to recognize symptoms, know something of the disease, and the final outcome before she can intelligently treat the patient. This course should begin with the idea that a mentally afflicted person is ill and needs the most intelligent and scientific care. In the very beginning the nurse must be made to appreciate that this type of nursing calls for the greatest intelligence, most tender sympathy, and most scientific training. A very important point to impress upon the nurse is the fact that her chief and most important duty as a psychiatric nurse is to aid in the rehabilitation of her patient and to return him to society in the shortest time possible.

In the study of a psychiatric patient, the nurse must investigate the physical condition first, because often a physical ailment may be the cause of the mental disturbance. The student must be instructed to note if there are any acute symptoms such as coughing, expectorating, pallor or cyanosis, injuries, marks of violence or deformities, and if such exist, attention should be given immediately. The nurse must be instructed to inquire into the kind of diet the patient has had, the amount of sleep with all its variations and their causes. No further instruction in the above will be given, because such knowledge should have been acquired from the course in practical nursing.

Symptoms Must Be Recognized

We now turn to the mental aspect of the situation. The first requisite of the psychiatric nurse from the mental view point is to be able to recognize symptoms. Many of these are of such insidious nature that it often requires months of experience to get fairly proficient in ascertaining the true condition of the patient. Great emphasis is placed on the importance of keen and accurate observation. The nurse must be constantly observing without giving the patient the slightest idea that his behavior is giving her any concern whatsoever. The success of the treatment of mental disorder depends almost entirely upon the early recognition of symptoms.

In the course in psychiatry, the psychiatrist discusses the different diseases and takes up the more pronounced symptoms but, in order to give the nurse sufficient instruction to enable her to appreciate the various mental symptoms, it is necessary to take up the subject more specifically in the course in psychiatric nursing. The nurse instructor should so arrange her course that it will correlate with the course in psychology. Such subjects as sensation, perception, consciousness, memory, attention and association, judgment, affectivity, reactions and personality should be carefully discussed. The instructor must be convinced that her class has a psychological under-

Student nurses keep fit by their regular gymnasium work. The picture shows a class of student nurses in their gymnasium.

standing of the subject she is to take up at that period. This is followed by a careful study of the disorders of that particular mental state; illustrations are given either by actual examples known by the nurse, or typical illustrations are given to make the lesson more interesting and instructive.

In addition, the nurses are requested to make observations with the idea of detecting these particular symptoms in the patients on the wards where they are working. A report will be given when the class meets next time. The nurse must inform the class in what diseases these particular symptoms are most common. Study of this kind makes a complete correlation between theoretical subjects and the practical work on the wards. When the nurse understands the nature of certain symptoms, she will immediately comprehend the whole situation and know why her patients react to external stimuli as they do, or why their conduct is so totally different from what it would be under ordinary conditions. This method of treating the subject gives the student a just appreciation of her patient and paves the way for a scientific approach of psychiatric nursing. She sees the need of special training and study, and the great opportunity for research work by the nurse.

For the sake of illustration and to give you a better idea of how the mental states are treated in a course of psychiatric nursing, I will briefly outline one subject. One of the most interesting topics for class discussion is perception. Great care must be taken that the class understands the term; after that the disorders of perception are taken up as follows:—

(1) Insufficiency of perception.
(2) Inaccurate perceptions (illusions).
(3) Imaginary perceptions (hallucinations).

Since perception has to do with the senses, the disorders may affect any of the senses. Therefore there are many varieties of these particular disorders. Each one should be taken up separately and discussed from various angles such as, their etiology, their relation to other mental disorders, and the many theories concerning the disorder. In addition to this, a careful survey should be made of the influence of those abnormal conditions upon such psychic functions as attention, judgment, memory reactions and affectivity. The instructor should have made a careful selection of patients who are suffering from the disorders discussed and have the nurses talk to them. Finally a list is made of all mental disorders and diseases showing the symptoms just studied.

Nurse Needs Self-Control

Following this the student is shown how to correct and treat these abnormal conditions. Attention is called to the importance of correct habits both mental and physical. As we study the insane, one is impressed with the fact that their abnormal conduct is made up of a bundle of bad habits, which accounts for their maladjustment to society. Educators in psychiatric schools should make it their chief concern to impress upon their students the importance of good habits in thinking and acting. No psychiatric nurse can be successful, if she neglects her own character, for how can she support the weak character, how can she guide the unfortunate under her charge, unless she has strength of character. The first habit brought to the attention of the student is self control which is the mainspring of character. The characters we meet in the hospital have lost control of themselves completely and it is the duty of the nurse to teach them the habit of self control. We cannot impart knowledge we do not possess, neither can we imbue others with the desire to obtain certain qualities of character we do not possess. Therefore it is necessary to instruct the nurse, and if need be help her to form the habits which she must teach the patients.

Many insane patients have lost all interest in themselves and their environment. Their level of conduct has descended to the lowest; their instinctive tendencies assert themselves and they adopt the most primitive ways of acting. They no longer care for their personal appearance, and have no interest in their environment. The student should be taught how to approach her patient in order to awaken interest or to create new interest. It is the task of the nurse to break down the bad habits by substituting new ones. This is done by studying the individual patient and trying out different methods until one is found to fit that particular case.

In caring for a psychiatric patient, the student is made to realize that one of her most important functions is to direct the patient along some line of work. A psychiatric nurse is a teacher and director. She does very little actual work, but insists that the patient carry out her ideas. Often this is much more difficult than if the nurse did the particular task herself. This would be very detrimental to the patient and would not be true psychiatric nursing.

Amusements Not to Be Neglected

Amusements play a very important part in the treatment of the insane and the student must have some knowledge of this subject in order to use the type of amusement suited to the particular disease. Gymnastics are excellent for nearly every case, because of the music and jovial spirit which is prevalent in a gymnasium. Then team work is most beneficial and will aid greatly in getting the patient in a better social attitude. Story-telling has been used with very good results. The nurses have many opportunities to use stories as one means of diversion, therefore every student in a psychiatric school should be given a complete course in the art of story-telling. Parties of every description are necessary in the care of the mentally disturbed. Nurses should have instruction in planning and conducting parties. These usually are given for the pleasure of large groups of patients and call for good system and co-operation.

Since occupational therapy has been such an effective therapeutic measure, our students must have some instruction in that subject. Occupational therapy is classified as, diversional, symptomatic, and educational. Diversional is the most common and least important type. It aims merely to divert the thoughts and attention of the patient without much consideration of permanent effect. This has its place in the treatment of nervous and mental disorders, and cannot be disregarded.

A more important form is symptomatic occupations, which are given to the patient, according to the symptems manifested. For example, a monotonous occupation will be prescribed for the nervous, restless patient. Those patients who formerly tore up mattresses, sheets, etc., in an effort to get rid of their surplus energy, now spend it in tearing carpet rags, sandpapering, knitting or crocheting. The student nurse must study the individual patient and give the occupation which will act as a check upon the restlessness present in the highly disturbed or serve to give relief from deep lethargy in other cases. Something which makes a strong appeal to the senses must be given. Every patient is an entity by himself and needs individual attention.

The third classification of occupational therapy is the educational type. Some consider this the most important.

This type is purely educational, and the aim is to train the patient by means of a useful occupation, to right habits of thought in systematic work, and strives above all gradually to lead him back into the ways of living peacefully with other people, and how to make adjustments to his environment. An eminent psychologist has said, the difference between the sane man and the insane man is this, the former can live in society, and the latter cannot. I do not believe there was ever a truer saying. There are many men and women in our state institutions, who do the work of experts, their activities seem almost perfect while they are inmates of the hospital, and they do the work of a number of employees, but they could not make a living on the outside. Fine examples of a poor adjustment in a civilized world! About seventy-five per cent of all state hospital cases are behavior cases. So you see how important it is for the psychiatric nurse to have adequate knowledge of habit formation, amusements and all forms of occupational therapy.

For the highly excited, hydro-therapeutic treatments have been found to be most effective. The psychiatric nurse must have instruction in hydrotherapy and massage. She must know how and when to give continuous baths, packs of various kinds, douches, sprays, showers, etc., because all forms are used as a follow up treatment after the hydrotherapy. This treatment is very short, but the nurse must be informed just how, when, and for how long it is to be given.

Special instruction must be given the student in handling the highly disturbed patients as well as some information in feeding the insane. Sometimes patients refuse to eat, but with study the nurse soon ascertains the cause and can remedy the condition. The last resort is tube feeding, but if the nurse is properly trained this is seldom necessary.

In a course of psychiatric nursing very little time and attention is given to special instruction in drugs, because very few drugs are given. The nurse has sufficient knowledge from her general course in materia medica so that special instruction in this line is not necessary.

Our last subject and one of the most important is the teaching of mental hygiene. I do not think we have any idea of what the psychiatric nurse will be capable of doing in this branch of preventive medicine. A nurse who can recognize mental diseases in their incipiency, and can give the mentally afflicted intelligent advice will be one of the greatest benefactors the community possesses. Can any form of service be more noble, more charitable than saving a man or woman from a nervous or mental breakdown? In conclusion, may I make an appeal to you to give some attention and consideration to this important subject? If you are interested in the education of nurses, will you not give your students the opportunity of getting some training and experience in the care of the insane? Ask your state hospital organizations to establish schools to which you will be willing to send your nurses for training. If the demand is in earnest the state hospitals will meet it.

FOUR MONTHS OF TRAINING IN PSYCHIATRIC HOSPITAL NURSING

By FRANCES PURCELL, St. John's Hospital, Springfield, Ill.

IN FEBRUARY, 1923, I entered the school of psychiatric nursing for the four months' short course which is offered to senior students of general hospitals. For some time previous, I had given the idea much consideration and thought, and I must admit I had very weird thoughts, almost uncanny, when I realized that I was to spend four months among men and women who had been adjudged insane. Nevertheless my desire to get some knowledge and experience in psychiatry was stronger than my fears, and at the appointed time I was ready to take up the new work. About twenty other young women who were senior nurses in different hospitals came in at the same time. It would be difficult to find a brighter, more alert, or more refined group of students. Each one seemed full of enthusiasm, anxious to get on the wards to learn something of this new field. Our first lecture was an introductory talk, consisting of a few words of explanation of what our attitude should be toward our patients, and points of difference between the duties required in a general hospital and a hospital for the mentally ill. The many conveniences of the nurses' home were made known to us and we were made to feel that we were most welcome, that the home was ours for the next four months, and that everything would be done to make it as homelike as possible. As time passed we realized more and more that the home was really ours, and that it was a place where we could enjoy ourselves to the fullest extent, when off duty.

At seven o'clock the next morning every nurse was ready to go on duty. We were taken in groups to the different cottages, where we were to work. The whole plan was so different from our home hospitals, that it took some time for us to get adjusted, and to realize that a cottage was not a small frame house, but a large brick building accommodating from a hundred to 200 patients. We soon learned that, as with most hospitals, the motto was "The Patient First."

Our duties differed, depending entirely upon the type of ward on which we were working. We were greatly enlightened to find that there were many different classifications of nervous and mental disorders and that the treatment was varied. The difference in many cases was as great as the difference in treatment of surgical cases.

Teaching—An Invaluable Therapeutic

We had regular assignments as in a general hospital, but our duties consisted more of teaching the patient how to think and act, and thereby take care of himself, rather than care for him as we do, when nursing a physically ill patient. The habit-training wards were very interesting. After seeing that the patients were properly dressed, we would begin the occupational therapy classes which would last until dinner time. After dinner, class was resumed and continued until three o'clock, when all the affiliated nurses went off duty. The class work on these wards depends entirely upon the type of patients and their mental condition. On some wards we would have mostly re-educational work, which would consist of lessons in the personal care of the patient. This would be followed by lessons in sew-

ing, knitting or drawing, with dances and games intervening. At a certain time each day, we would take the patients to the gymnasium for their daily exercise. A large number of the patients as they advanced in their occupational lessons are sent to the occupational center, a large building devoted entirely to occupational work, where they make articles of various kinds. The making of toys is a very delightful occupation for both men and women. All through the year patients are busy and very happy making toys which at Christmas time are given to Santa Claus who distributes them to poor children.

On certain wards our attention and efforts are mainly centered on the patients who cannot or will not enter the classes. My main attraction and delight for this type of patient was in story-telling. Very often I would bring ten or twelve patients together, have them arrange their chairs in a semi-circle and start to tell a story. Before long one or two would walk away, while a few would sit staring into space. Others would show interest and seem delighted with the story. Occasionally one would tell a story very much as I had told it, while another would ask for it to be repeated. Even the slightest sign that the story was enjoyed by a few made one feel that the work was worth while. Walks about the grounds were taken daily. These were considered the big events of the day, and not to be allowed to go was as great a punishment as could be imposed. To walk with the nurse was a place of honor taken by turn.

Interest in Hydrotherapy Department

The hydrotherapy department for the acutely disturbed was considered by many of the nurses to be the most interesting of all. It is certainly gratifying to see the highly excited patient calm down after a hydrotherapy treatment. The receiving services were also very interesting. In these wards the patients are given about the same care and attention as is given to a physically ill patient. Everything is done to assist the patient in adjusting himself to his environment and to aid him in getting well as soon as possible.

The theoretical work was excellent in every respect. Although it was very heavy there was not a subject or lecture we would have omitted. One large building of the institution is turned over to the school of psychiatric nursing for educational purposes. This contains two large lecture rooms, one demonstration room, and one laboratory. The library of the Chicago State Hospital also occupies one room. The school has the privilege of using this library. This makes it possible for the student nurses to get almost any book that she may desire, in fiction or science, as the library is a branch of the Chicago Public Library.

We had the following courses, which are arranged as to hours, method of instruction, etc., on a college basis. Anatomy of the Nervous System, Psychology, Psychiatric Nursing, Psychiatry, Hydrotherapy and Massage, Occupational Therapy and Mental Hygiene. Our instructors were all experts in their subjects and each gave a very comprehensive course of lectures. Many of the lectures made a lasting impression, giving us thoughts which will assist us in our daily life, making us better nurses and arousing in us greater desire to do more for suffering humanity.

That the importance of recreation was not overlooked was evident in the good times we had together. A pleasant living room in the nurses' home was one of the chief attractions. Comfortable chairs, lamps and magazines were always awaiting us; a victrola made dancing possible at any and all times, and a tiny kitchenette with pop-corn and material for candy was at the disposal of those desiring to use such.

It is not possible for me to express all that I received from those four months so that I earnestly entreat other nurses who are interested to take this course.

AMERICAN COMMITTEE PLANS MODERN SCHOOL OF NURSING FOR PARIS

ONE of the most modern, if not the most up-to-date, training school for nurses in all Europe, will be built in Paris shortly. The training school will be conducted in cooperation with a new hospital, equipped with every modern appliance as well as the latest design in hospital architecture and arrangement.

Announcement of the new project is made by the American Committee for Devastated France. The American Committee has the active cooperation and support of Major-General Merritte W. Ireland, surgeon-general of the United States Army, who recently commissioned Major Julia C. Stimpson, chief of the U. S. Army Nurse Corps and dean of the Army School of Nurses at Washington, to go to France and examine the American Committee's plan at close range.

Dr. C.-E. A. Winslow, professor of hygiene and health at Yale and Columbia, is chairman of the sub-committee of the American Committee for Devastated France, charged with the details of organization and management of the training school. This sub-committee numbers among its members many of the most prominent doctors and experts on nursing work in the United States including Dr. G. G. Parnall, professor of nursing and health at the University of Michigan; Dr. Richard O. Beard who holds a similar chair at the University of Minnesota; Dr. W. H. Welch of Johns Hopkins University; Miss Adelaide Nutting, professor of nursing and health at Columbia and organizer of several nursing schools in America; Miss Katherine Olmsted, chief nurse, League of Red Cross Societies, Paris; Miss Clara Noyes, director nursing service, American Red Cross, Wshington; Dr. W. C. Rappleye, professor of health at Yale; Miss Annie W. Goodridge, superintendent of the Henry Street Nursing Settlement, New York, and assistant professor of nursing and health at Columbia, and many others.

Brought About by Our War Services

The decision of the American Committee for Devastated France to build and endow a training school in Paris is a logical outcome of its nursing and public health work in the devastated regions and the desire of the leaders in the French medical profession to render permanent the standards of nursing and public health work established in the Aisne as a result of the activities of the American Committee.

While France can easily hold her own with the rest

of the world in her medical and surgical achievements, it is incontestable that she is far behind them in nursing and public health work. From the earliest days of the committee's work in France this shortcoming was apparent. Broadly speaking, the nursing profession did not exist in France, the work of caring for the sick being regarded as a field for the unintelligent servant type, the trained nurse being an almost unknown quantity. One little school alone, directed by Dr. Anna Hamilton, a French woman of Scotch descent who may rightfully claim the title of "the Florence Nightingale of France," was striving at Bordeaux to raise the standard of the profession and train nurses who should be worthy of the name.

Miss Evelyn Walker, now head of the nursing and public health service of the American Committee, came to France from America in 1918 and was assigned by the American Red Cross to work with the Bordeaux School. Under her direction, a four-months course in public health work was organized at the school. In January, 1920, Miss Walker developed and enlarged the nursing service of the American Committee in the Aisne, started by Mrs. Mary Breckenridge in February, 1919. Now every child in the committee's region is followed and cared for from birth. The committee's nursing service comprises pre-natal clinics and classes, baby clinics, preschool, care medical examination of school children, bedside care and ambulance service.

All of the nurses employed in this work were French and each one provided an example of what the French nurse could be, if properly trained and directed. The success achieved by the American Committee encouraged those few French pioneers who believed in the possibility of training French women for this work, and the "better nurse" movement in France was given a great impetus. Dr. D. A. Calmette of the Pasteur Institute took the lead and, gathering around him prominent doctors and others interested, started the movement for the establishment in Paris of a school which should graduate nurses of the type turned out by the Florence Nightingale School at Bordeaux and the American Committee. They asked the American Committee to help them. It was pointed out to the committee that unless something was done to ensure a permanent supply of qualified nurses, the committee's work in the Aisne could not develop after the committee withdrew from France.

Dr. Ernest Rist, president of the Rue Amyot Nursing School at Paris, who has made valiant efforts to advance nursing standards in France, but whose school is handicapped because of the lack of affiliation with an up-to-date hospital, offered to cooperate with the American Committee in establishing a new school. The problem of hospital affiliation was one of the most serious difficulties before the committee which tried to effect an alliance with the big hospitals of Paris under government control. These hospitals are dependent to a great extent upon the Union of Hospital Employees, which has 80,000 members who regard any attempt to raise nursing standards as a blow aimed at them.

Difficulties of this sort seemed about to prevent realization of the committee's training school project when an organization of French doctors, headed by Dr. Oberthur, which had long been planning to build and equip a new and modern hospital, came to the committee with its plan, which had for its object the building of a modern hospital designed particularly to afford first-class medical and surgical service to those of small means at rates within their reach, and put an end to the just criticism that good medical care could be had only by the rich in France.

Dr. Oberthur already directs a small, but well equipped, modern hospital at Antouil, near Paris. His plan is to enlarge this hospital so that it may accommodate 350 beds, each in a private room, and afford space also for children's wards and dispensary service. Private rooms will be available at from 15 francs a day, the profit derived from the more expensive rooms being applied to effect the deficit occasioned by the concessions made to the needy. Eight million francs will be raised by Dr. Oberthur and his associates to carry out his plan. The American Committee's project is to build on land adjacent to Oberthur Hospital, a building containing 150 rooms, to equip and furnish, to organize in it nurses' training school, back it financially for two or three years, and to supply for its permanent maintenance an adequate foundation fund. One million dollars will be required to carry out this program.

PRESENT TENDENCIES IN NURSING EDUCATION*

"Your presence here indicates that you have demonstrated your right to the confidence of those able to judge of the quality of your efforts, but you know quite as well as I that your fitness to serve the world will be determined by what you do and say after you have left the guiding influence which has directed your steps in these historic corridors. . . . .

"You go out from these walls with a mental equipment and a professional training hardly dreamed of a generation ago. Remember that your splendid opportunities have been made possible through the high minded idealism and self sacrificing devotion which the leaders in your profession have shown in the advancement of nursing. . . . .

"Your aspirations today can be essentially no different from those of your first great leader, Florence Nightingale. If you must still struggle and endure in order to get more education, it is only to enable you to give more in effective, unselfish service. . . . .

"The role of the nurse in the program of the new public health is an increasingly important one. More and more she will be the trusted messenger who carries the lessons of hygiene into every home. . . . .

"To supply nurses in sufficient numbers to meet the public demand is even now a national problem. . . . .

"The interest of the public demands that the trained attendant, nursing aide, or practical nurse, must have her status defined by law and her activities limited to the sphere for which she has been prepared. . . . .

"There is an increasing demand for nurses who have the education and experience necessary to qualify them as teachers of nursing and as nurse executives and leaders in various special fields.

*Abstract of the address given before the nurses' graduating class, Massachusetts General Hospital, Boston, by Dr. Christopher Parnall, University of Michigan Hospital, Ann Arbor, Mich.

SOME PROBLEMS OF NURSING IN SMALL HOSPITALS*

By MARY A. LAND, R.N., Mount Vernon Hospital, Mount Vernon, N. Y.

THERE are individuals who "rush in where angels fear to tread," and, not content with the difficulties of hospital management, take upon themselves the added problems of a training school in the so-called small hospital. Generally considered, the small hospital is an institution of from fifty to one hundred beds, averaging forty to seventy patients daily.

The chief function of every hospital today is service to the patient which includes adequate care and every possible attention to his physical and mental comfort. A hospital of 100 beds has an opportunity to train nurses, provided justice can be done the student nurse. Almost within the memory of everyone present, a complete change has taken place in the attitude of the public toward the hospital. It is no longer regarded as a place from which everyone should stay away, if possible, but rather an institution essential to public service and to human welfare. The pendulum has swung the other way, and hospitals are usually overcrowded, taxing to the utmost the bed capacity and nursing service.

Boards of Managers Need Educating

With this situation and the proposition of maintaining a training school, one of the hardest problems to solve is educating the board of managers and the public of the community as to what is due the student nurse. To many of the laity, even yet, maintaining a training school is providing nursing care at small expense to the hospital. In the mind of the public, nursing itself is generally understood to be carrying out the doctors' orders. They think of the education of the nurse as something entirely different from that of preparing students for other fields, and therefore cannot see the need of supporting schools for nurses as other schools are supported. More active and interested training school committees can help materially in this education and will also be of practical service in raising funds for training school purposes. In order to adequately care for the sick, we must abandon the attempt to assign to pupil nurses exclusively the task of caring for the patients in general hospitals, and this brings to us the problem of the graduate group for general duty.

The personnel of this group is constantly changing, for the majority seem to be affected with a restlessness which does not permit of gathering moss. Individual members are a great joy. They adapt themselves to local conditions, are interested in the student body, and speedily become part of the hospital family. However, as every hospital and training school superintendent knows, many are not of this type; they feel no loyalty to the hospital, physician or patient, and if anything unpleasant occurs, leave at a moment's notice with no consideration for patients or hospital. The necessity of employing graduate nurses for general duty adds greatly to the problem of supervision, for they come from different training schools and have different methods for the various nursing procedures, which often prove disastrous to the young student nurse. Almost all schools employing graduate nurses desire to give the student nurse the minimum of night duty but, unfortunately, it is difficult to obtain sufficient graduates to cover this service.

The problem of the special nurse is a big one. Physicians often ask the question, "What is the matter with the special nurse?" Investigation brings conclusions which are far from new. Some special nurses are beyond praise, taking excellent care of their patients, causing no friction in the hospital, and forming a splendid example to students as "a fine type of private duty nurse." On the other hand, there are nurses so negligent or so disqualified by personal characteristics that patient and institution hope they may never have to see them again. We are all familiar with the nurses who report late on duty and leave early if possible, expect personal telephone calls during duty hours, pay no attention to their professional appearance, spend a great deal of time in the chart room or corridors talking and laughing, and frequently criticize the institution and its administration even while they are registered for "hospital duty only."

They do not try to conform to hospital routine regarding special diets, care and use of hospital linen and equipment, and yet are the first to complain to physicians and patients that they cannot obtain certain supplies or articles of food.

Personally, I think that the hours of duty should be restricted from 7 a. m. to 7 p. m., as "night specials" are almost extinct, and frequently special night nurses of whom one does not approve are employed, rather than leave critically ill patients to general floor care.

That proper instruction be given the students is one of the chief problems in the training school of the small hospital. Even where funds are provided, it is difficult to obtain qualified instructors, as the demand exceeds the supply, and the field in the large schools offers more opportunities, and is of greater interest to the instructor.

Place of the Central School

In Westchester County, five schools have combined to form a central school to give the theoretical work of the four months' preliminary course. This central school has been given the privilege of using the educational building at Bloomingdale Hospital, White Plains, and beginning with the September class, the students have spent the mornings in their home schools, and from 2 to 5 p. m. five afternoons a week at the central school. The teaching is now being carried on by a qualified instructor, and in the near future, we hope to extend the work and have an additional one.

Many situations found in small hospitals are due to the difficulty of adjusting the conflicting claims of hospital management and nursing education where no special fund or endowment exists for training school purposes. However, progress is being made, and hospital directors are realizing more every day that the school of nursing is an educational institution and must be maintained for the purpose of providing the community with the services of competent nurses for the care of the sick and the carrying forward of the campaign for public health.

Miss Claribel A. Wheeler has accepted a position as director of the training school for nurses, Washington University, St. Louis, Mo. Miss Wheeler was formerly at the Mt. Sinai Hospital, Cleveland, Ohio.

Miss Margaret Schneider, R.N., class of 1923, St. Elizabeth's Hospital, Lincoln, Neb., was married to Mr. Thomas Bermaster of Aurora, Neb., where they will make their home.

*Read at New York State Nurses' Association, Buffalo, N. Y., October, 1923.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

INSTITUTIONAL ECONOMICS APPLIED TO HOSPITAL DIETETIC PROBLEMS*

BY RENA S. ECKMAN, DIRECTOR OF DIETETICS, MICHAEL REESE HOSPITAL, CHICAGO, ILL.

SOMETIMES it has seemed to me that from the standpoint of home economics the question of hospital economics has been attacked with considerable hesitancy and that investigations which have been made proceed only up to a certain point. The crux of the situation is often not reached, or the approaches to it become so intricate that the student is often lost in such a maze that she can no longer "see the forest for the trees," and helplessly abandons her explorations to some future aspirer, predicted to happen along at a station rather near to the millennium.

Comparing hospital economics with other branches such as exist in dormitories, cafeterias, restaurants or hotels, we find that on the surface there is a certain similarity of problem. We all feed and in some cases house the larger family. We all contribute largely to the health and happiness of those who patronize our tables. Far more than we realize we withhold, or place at our guest's disposal, the materials which comfort, nourish and protect the body from the ills that flesh is heir to. For all of these blessings some institutions receive credit and praise; others receive only a moderate share of honorable mention, while to a third class, in which many hospitals find themselves placed, commendation is a rare occurrence, prison fare seems the nearest comparable simile and little parodies and mild epithets are often found to be good-natured meal accompaniments.

Combatting Dissatisfied Employees

While there may be a few isolated examples of hospitals in which such a depraved condition of the dietary really exists, dietitians know full well that many factors, often absurd ones, enter into the causes which lead to the voicing of untrue, defamatory judgments. Hotels recognize the part that psychology plays in this problem. They also recognize the fact that the space required to house and feed employees could be very profitably used for other purposes. Hotels know that overhead costs, profit and loss are just as necessary considerations as the satisfied and happy guest. Many of them find that it is quite possible and convenient to arrange to have their help live outside. The moral issue is, in a sense, dodged by this movement, as will appear later on. Complaint and disturbance are removed by requiring employees to take their meals elsewhere, but it is a well-known fact that the cost of those meals is not entirely removed. Food is too easy to procure on its journey to and from the guest. The hotel need not care since it can readily charge the guest in proportion to the cost. The hospital in this case is not so fortunate, being in a measure at least a charitable institution. Food may fluctuate in cost but cannot be charged to the consumer. If the menu is adjusted and the variety becomes small or the quality poor, the institutional family detect it at once and trouble brews.

I do not believe that the hospital food problem can be solved until the whole question of economics is understood by the authorities who manage the institution. To some it may look as if I were avoiding the issue altogether by the statements which I am about to make. To others they may be a familiar story, at least in most of their aspects. The hospital has several classes of people among its personnel. Those whom I allude to as employees consist in the main of the non-professional class—many of them highly paid, as engineers, plumbers, electricians, accountants and other office employees, departmental supervisors, and the whole personnel of the culinary and housekeeping department. The salaries and wages of these people are fairly well standardized, as their work is similar in character to that done all over the world. Custom has already arranged for a large number of these people to live outside of the institution. How about the remainder of them? A relatively small percentage of the people need to be close at hand because of the character of the work required.

Advantages of Outside Housing

With space as limited as it often seems to be in hospitals, many reasonable arguments can be cited for outside feeding and housing of employees. Any one who has observed the enormous waste of food in the institutional dining room would find an unspeakable relief, if this burden was removed from the departmental responsibility. When an employee realizes that a piece of bread costs one cent, he will either eat that piece of bread that he pays for out of his own pocket or else he will leave it untouched on the cafeteria counter. But if he has placed at his disposal unlimited quantity of food, the plate waste will often represent fully as much as the consumption.

It is not always apparent to the head of an organization why the feeding of employees causes so much disturbance. They perform so much physical labor that one would naturally expect the appetite to be keen, the taste

*Read before the meeting of the Home Economics Association, July, 1923, Chicago, Ill.

less critical and that they would overlook minor difficulties. Psychology, however, plays a large part here. Strange as it may seem, help will not take care of help. Individually, yes, but as a group, no. Cooks are pushed, crowded, urged and compelled to provide for the paying guest and those in authority, and their task is fraught with much worry, discomfort and physical weariness. Here a chance is presented where they may slacken. Unwittingly the remark falls from some one, "That is good enough for the Help," and the words are interpreted and soon spread broadcast: "Anything is good enough for the Help," "The Help get all of the left over food," "Nothing new or fresh is ever prepared for the Help," etc., etc., in consequence of which each individual comes to his meals anticipating an inferior quality of food, and whether or not the bill be true they resolve to take arms against unjust discrimination, "get even" with some one for their slights, and of course visit the sins of the Help upon the head of the Employer, for who else can be blamed?

Trouble Saved Through "Eating Out"

Living out and eating out would abolish a horde of evils. But before all that can be suitably arranged it should be known whether suitable accommodations can be found. Should this be impossible, or should it be an unavoidable duty to continue to house and feed the Help, I believe that it can be done with a great measure of success and satisfaction and will be by no means unappreciated, if their problem is studied from several angles.

They should have their own cook. That cook is the one to be held responsible for the success or failure of the quality and quantity of food. They should have a light, clean, respectable dining room or cafeteria. Dishes may be plain but should be whole, not made up of the chipped half broken articles discarded from other services. Their menu should be hearty but may easily be made to contain green vegetables. Even salads will be appreciated. If interest and attention is not awarded their diet by the dietitian the inevitable penalty results. If the dietitian does not care, no one will care. If the dietitian cares, she is sure to get more co-operation from many points along her hospital way.

It should be rated as a distinct privilege for an individual to be allowed to sleep in the hospital and to take his meals in the institutional dining room.

Now we come to that important class of individuals without whom we cannot run a hospital and about whom we can never say "They are satisfied." It has been said and perhaps well said that two classes of people can never be fed satisfactorily—school teachers and nurses.

Many of the reasons why the help are difficult to feed apply also to the nurses' food problem, but a few more also enter in. If the hospital does not operate a training school for nurses and employs only trained graduate nurses, they could also be required to take their meals outside of the hospital and their salaries be adjusted to a suitable allowance. As the hotel guest pays for the cost of service, the hospital patient would have to do likewise. In some ways this arrangement would be much better for the private nurse, for by this means she would be compelled to take fresh air and obtain a little out-door exercise. The hospital could dispense with this piece of work and thereby be much relieved of a burden which often becomes onerous.

But we are obliged to view matters from still another standpoint and that is, "What does the hospital stand for in the community?" Because of its existence thousands of individuals receive medical, surgical or emergency attention yearly. Young men receive much help toward the graduate study of clinical medicine; young women are permitted to obtain an education that fits them for a profession exceedingly useful to themselves and to the community.

Health Through Hospital Housing

The institution that carries on so noble a work, is generally in a position to house and feed its personnel in better fashion than those people can get by going outside and individually procuring their own accommodations. And for the average student it does do this.

There are enough studies in existence to show us that the pupil nurse costs the hospital but little more than the graduate nurse in housing, food, text books, uniforms, and care. I do not refer, of course, to the conscientious high class woman whom we often meet in hospitals, who regards hospital property with as much sacredness as she does her own, and whose interest in her patient and her work for that patient far exceeds her care for her own personal comfort.

If current comment be true, the average graduate special nurse cooperates but little with the management, being interested primarily in her patient, and the institution looks rather to the average student nurse when it needs self-denying response to emergency work. So by common consent the best hospital extends its service to the community a little further, tries to provide for all physical necessities and adds to those necessities many advantages. Taking our cue from the institution in its philanthropic service we clearly see our duty in providing a suitable home and food. More than this we must throw around the young pupil nurse influences calculated to counteract those which are all too numerous in hospital life and tend toward cynicism, lack of faith, and lowered ideals.

I cannot say to you that home economics is responsible for all of these provisions, but our dietitians, our social directors and our superintendents of nurses are individually and collectively deeply involved. The nurses are often young girls still needing the food requirements of the early post-adolescent period. Their standards of life are by no means formed and the older individual in the hospital commits the unpardonable sin of causing those youthful ideals either to cease to develop or to fall.

Obstacles to Dietetic Management

How the dietitian is to do her part is the question uppermost in your mind. It should not be extremely difficult to serve three meals a day, have them satisfying and palatable and yet give the necessary variety. Wherein do we fall short if the accusations are true and we really are starving our people? It seems incredible to the casual observer, but several reasons can be given for our blasted reputation.

First, the dietitian in a hospital, especially in a large one, seldom buys and, even if she has the power to refuse unsuitable goods, this very fact often leaves her with nothing to substitute in the menus but an absurdly small variety, instead of the articles of poor quality which she has just turned away. The cost of food can not be ignored and careful purchasing is a necessity. Should this office of buying devolve upon a business agent whose point of view is uneducated or is most unhappily circumscribed by the rim of the dollar, she will have infinite trouble in keeping either variety or suitable quality of products on hand. Fresh fruits and vegetables will be far below the physiological needs of certain vitamins and accordingly the appetite will be sharply influenced by the lack of fresh vegetables and fruits. Once the appetite becomes poor a

whole train of evils follow. Dissatisfaction, wrong habits of eating and eating between meals become habitual and the vicious circle is completed. The food is rated as bad, the dietitian dubbed incompetent and the hospital superintendent considered mean and stingy.

Proper Serving Facilities Lacking

Another factor entering largely into the causes for complaint against hospital food is the lack of proper facilities for serving. How many hospitals have been built and considered large enough to accommodate the needs of the community for at least a score of years, only to find that within five years there is not enough housing space for the hospital personnel and the service provisions are utterly inadequate.

Lack of space is bad enough, but arrangements of dining rooms, pantries and kitchen are infinitely worse. Who can expect to satisfy a guest when plates must be cold? What guest can be made to believe that badly planned space, inadequate space, lack of machinery and gloomy location are excuses for unsatisfying meals. The guest comes to our table to eat, to satisfy his hunger, not to make allowances. Deficiencies are not only found in the culinary department, but just as often can be traced to poor storage and inadequate marketing facilities.

With the co-operation of the hospital authorities things are being done to circumvent many of the difficulties. In some cases it has been possible to build an outside service building where kitchen, service rooms, and dining rooms can be laid out anew and modern ideas developed. Other hospitals have solved the matter by putting the kitchen in the nurses' dormitory and here again the solution appears to be satisfactory. The Michael Reese Hospital is looking forward to this latter plan to relieve the crowded condition brought about by an overgrown hospital and consequently an overworked dietary department.

If I were to presume to give advice to an institutional dietitian in the most difficult division of her work, that of feeding the non-paying guests or the non-paying patients, I would say:

Give them the square deal to the utmost of your ability and to that end know your job before you undertake it. Insist upon adequate equipment and proper and prompt repairs. Either buy or influence the buying so that you can have control over the menu for which you are responsible. It is not the actual cost of the menu; it is the cost, the variety, plus the service, and lastly the mental set, that counts for happiness along the dietary path.

FIRST CLASS OF DIETITIANS GRADUATED FROM U. S. ARMY HOSPITAL

Walter Reed Hospital, Washington, D. C., has the distinction of graduating the first class of dietitians from a U. S. army hospital. Graduating exercises for the eight women who had just completed the training course took place December 28, 1923, at 3 o'clock in the conference room of the administration building.

Major H. C. Coburn, Jr., director of the course for dietitians, presided at the exercises. After a few remarks concerning the nature of the work just completed, Major Coburn introduced Dr. William Gerry Morgan, professor of gastro-enterology, school of medicine, Georgetown University, who delivered an interesting address on the development of the science of feeding the sick.

Major General Merritte W. Ireland, surgeon general of the army, spoke a few words to the graduates before presenting the certificates. The eight graduates are Esther N. Beach, Doris Buck, Gladys Castle, Caroline Z. Miller, and Elsie E. Wells, Battle Creek School of Home Economics, Battle Creek, Mich.; Ruth Beach, Florida State College for Women; Linda Clements, Oxford College, Oxford, Ohio; and Florine Sunier, Milwaukee-Downer College, Milwaukee, Wis.

Four of the graduates will remain at the hospital, two will go to other army posts, and two will return to civil life.

The next class for junior dietitians will be admitted on or about September 1, 1924. The course lasts six months, which time is spent in the special diet kitchens, main kitchens, ward kitchens, and hospital laboratory, with two weeks' affiliation at the Children's Hospital.

Instruction is given in diet in disease, general medicine, general surgery, communicable diseases, marketing, hospital sanitation, and the teaching of practical dietetics to student nurses.

MASSACHUSETTS DIETITIANS ANNOUNCE OFFICERS AND PROGRAMS

The Massachusetts Association of Dietitians announces the following officers for the coming year: president, Amalia Lautz, Peter Bent Brigham Hospital, Boston; vice-president, Quindora Oliver, Children's Hospital, Boston; secretary, Emily Riley, R. H. Stearns Employees' Cafeteria; treasurer, Margaret Eastman, Federal Reserve Bank Employees' Cafeteria; parliamentarian, Ruth Wallace, Phillips House. The committee chairmen are as follows: membership, Louise Eliot, Neighborhood Kitchen; publicity, Margaret MacGovern, Boston City Hospital; program, Quindora Oliver; constitution, Ruth Wallace; publication, Betty Hammett, Peter Bent Brigham Hospital, Boston.

The following programs for the coming year have been scheduled.

February 12—Lecture 8 p. m., Schrafft's, West Street.
"Personnel Management," Mr. G. Shattuck, manager, Schrafft's, West Street.
Supper 7 p. m., Schrafft's, West Street.

March 11—Lecture 8 p. m., Perkins Hall.
"The Place of the Department of Health in the State Nutrition Program," Miss Lou Lombard, health instructor of nutrition, state department of health.

April 8—Lecture 8 p. m., Perkins Hall.
"Current Scientific Literature," Dr. Alice Blood, president, N. E. Home Economics Association.
Exhibit—"Available Nutritional Material in Boston"
Amherst Extension Division
Boston Dispensary
Children's Hospital
Massachusetts General Hospital
Peter Bent Brigham N. E. Deaconess Hospital
State House.
7 p. m. Supper, Perkins Hall.

May 13—Lecture 8 p. m., Perkins Hall.
"The Dietitians' Responsibility for the Prevention and Treatment of Diabetics in Massachusetts," Dr. Elliott P. Joslin.

May 23—Business Meeting 3:15 p. m., Women's City Club,
Tea—4:00, Women's City Club.

Miss Edith Beshore, City Contagious Hospital, was accepted as a member of the Association at this meeting.

Miss Janet Loriched has accepted a position as assistant dietitian, Eastern Maine General Hospital, Bangor, Me. Miss Loriched took student training at Muhlenberg Hospital, Plainfield, N. J.

Self-trust is the essence of heroism.—Emerson.

THE PLACE OF THE DEPARTMENT OF DIETETICS IN THE HOSPITAL COMPOSITE*

By A. C. BACHMEYER, M.D., Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.

IT IS usually conceded that the primary purpose of all hospitals is to render adequate and competent medical and surgical attention to sick or injured persons and in every other way to care for their needs while they remain in the institution. In the efficient performance of this service numerous activities are necessary all of which either directly or indirectly bear upon the main purpose of the institution.

Considering these facts, it is essential when planning the internal administration of such an institution, that we analyze the various functions to be performed and the purpose of each, group them in logical and orderly manner and then assemble those groups of activities in the best manner possible in order to produce a well-balanced and efficient mechanism; one in which opportunity for friction has been eliminated or reduced to a minimum.

Many of these activities will naturally fall into groups and these groups have long since been recognized as essential departments in the hospital composite. Largely because of limited capacity, it is necessary, in many institutions, to combine (what in larger hospitals would be) two or more such departments and the principles of orderly division of duties are often overlooked or forgotten. It is well, however, to have in mind such divisions of function and purpose even though they be placed in the hands of one official.

It might therefor be well to consider the activities that may logically be assembled under the title "dietary department" before discussing the place of that department in the hospital organization.

Activities of Dietary Department

Briefly we group in that department all activities that have to do with food. More particularly, we usually require that the dietary department perform the following duties:

1. To plan the menus for every meal served to all of the patients and, in addition, also those for the entire hospital personnel.
2. To obtain, (preferably through requisition on the Purchasing Agent or storekeeper and in close co-operation with him) all raw food in the proper and most economical quantities.
3. To operate efficiently one or more kitchens in which such raw food is properly prepared for service (in digestible and appetizing manner) and to have such food ready for service at a definite time, in accordance with pre-arranged schedules.
4. To see that the food is properly conveyed to the place of service.
5. To analyze the unused portion returned and to use the knowledge gained from such analysis in the future planning of menus and preparation of food.
6. To conduct the various dining rooms for the personnel and to serve that personnel in intelligent, systematic and satisfactory manner.
7. To maintain all equipment used in sanitary condition and to observe the best hygienic and sanitary practices throughout the quarters occupied by the department.
8. To cooperate intelligently, with the professional staff in the therapeutic use of diet wherever indicated.
9. To instruct patients, when necessary, in the management and preparation of special diets, after their discharge from the hospital.

These, I believe cover the major activities of the "dietary department," though there are no doubt a number of others not enumerated. I purposely have not included "service of food to the patient," for I am of the opinion that this is a nursing function. It is one of those borderline functions where a clear understanding of duties and close cooperation is essential to good service.

This outline of duties coupled with the fact that it is through this department that the expenditure of a major portion of hospital operating funds is made, gives us some idea of its relative importance in the organization. If we will give a moment's thought to the important part that food plays in our lives, how much of the time of the housewife is consumed in planning and preparing food for the family, we may gain some further idea of the important role which the dietary department occupies in the administration of the hospital. The service it renders the patient is often his chief recollection of his hospital experience and an institution's reputation can easily be enhanced or injured by the type of service rendered by this department.

Therefore, it is my opinion that the dietary department should be considered one of the major departments in our organization and should not be subordinated to any other. As such, it should be given equal rank with the other major departments and its chief should report direct to the chief executive officer of the institution and be under his immediate supervision and responsible solely to him for the conduct of the department.

Requisites of a Dietitian

As head of the department, the dietitian should be one who has had a broad and thorough education and as much experience and training as possible. The salary paid and the opportunity for development offered will probably materially affect the calibre of individuals obtainable, but the amount of responsibility and quantity of work will help balance the scales.

Having secured a dietitian competent to supervise a department that will perform the functions outlined, she, with the superintendent, should analyze the work to be done and a definite scheme of organization for the department should be set up, defining the number and type of positions and prescribing the requirements and duties of each, fixing so far as possible the scale of wages in each position or at least establishing a minimum scale. The head of the department should then be given authority to secure the employees provided for in the plan adopted and should also have limited authority to dismiss them. The only limitation I would place on her authority to employ or discharge would be that a full report concerning the individual, his former employment and qualifications be made to the superintendent and that before discharging anyone, a specific report showing cause for dismissal be made, with the further understanding that any employee dismissed or otherwise disciplined should have the right of appeal to the superintendent.

*Read before the second annual conference of the Ohio Dietetic Association, Columbus, Ohio, May 22, 1923.

Having such authority and having a prescribed and mutually agreeable plan for the conduct of the department, the superintendent should hold the dietitian responsible for the operation and administration of her department, in the same manner in which his board of trustees hold him responsible for the administration of the entire institution.

In talking with many superintendents and after visiting numerous institutions I have felt that in a number of instances, the dietary department through subordination to some other department had suffered a certain neglect, which was no doubt the reason for many of the difficulties that had been encountered.

A proper scheme of organization is necessary in every institution, but such scheme alone will not produce efficiency and contentment. All the factors that enter into good administration are equally necessary, and cooperation must be encouraged in every possible way in order to promote inter-departmental confidence and goodwill and produce the best results.

HOW THE HOSPITAL DIETITIAN MAY HAVE CONTACT WITH ADMINISTRATIVE PROBLEMS*

By HERMAN SMITH, M.D., Superintendent, Michael Reese Hospital, Chicago, Ill.

NOT many years ago, a dietitian's accepted work was the teaching of nurses, and the preparation of special diets. Forward looking leaders of that time advocated and probably dreamt of the time when the dietitian would be able and then expected to bring her training to bear on all the food problems of the hospital. These leaders have lived to see the day when their then very radical programs have become accepted practice in many, I might say, most organizations where dietitians now have the entire food responsibility. With the acceptance of this responsibility, the dietitian's contact with the administrative problems has become many sided. I am afraid many dietitians would rather learn how they can get away from administrative problems than how they can be brought into contact with them. In most hospitals, one of the best ways to do the latter is to stand still; the problems will run over them. Enumerating a few of the problems, we find: the purchasing of food; managing the main kitchen and central diet kitchens, with all the attendant labor, cleaning, and food protection problems; the routing of food through the hospital; managing the floor diet kitchens; supervision of the food divisions of patient's charts; managing the nurses, employees', and guests' dining rooms, with all their attendant labor and cleaning problems; preparation of menus and their distribution and collection; milk formulae preparation; instruction of nurses, and patients; and aiding the physician. All these matters bring the dietitian into contact with administrative problems.

It is manifestly impossible to discuss even a few of these in a short paper, and I shall, therefore, confine myself to a discussion of a phase of the work which is most important, and probably one of the most neglected; namely, the distribution of weighed trays to the patient, and the charting of these foods.

Weighed Tray Service Neglected

By stressing this aspect of the dietitian's work, I do not want to be understood as denying the importance of her other problems, problems which in most of the larger, and many of the smaller hospitals she should and does solve. I have chosen it for discussion because even in the larger, more complex and supposedly more efficient hospitals, this phase of the work is neglected. Even in organizations where experimental metabolic wards are in existence, the organization or lack of organization in weighed tray work for patients throughout the hospital has usually been found to be as follows:

A supervised system of translating the physician's food prescription into food in the diet kitchen; the more or less supervised transportation of the weighed foods to the floors; reheating and setting up of these foods on trays by the floor student nurses under the quasi-supervision of the supervising nurses; the distribution of these trays under the same supervision; and the more or less supervised charting of these foods by the floor student nurses. Here we usually come to the end of all supervised or unsupervised work. The uneaten food is generally not weighed at all. In some instances, attempts are made to weigh it and in others it is actually weighed, the accounts calculated under supervision and the corrected amounts noted on the patient's chart. I have purposely repeated the word "supervision," because without it any hospital system is full of loopholes for error. With divided supervision, the chances for error are still too numerous to permit smooth working of the system.

Dietitian Responsible for Tray Service

Admitted that diet is our most potent agent in the therapy of diabetes, and weighed trays are ordered almost exclusively for these patients, it is hard to believe that we have been and, in most cases, are so careless with it. In no other department of the hospital would such carelessness knowingly be tolerated. The mistakes that occur in the long and devious route from the diet kitchen to the patient and his chart are many. Some of them, if they weren't so serious because they reveal the defects of the system, would be ludicrous. There is probably no hospital where a full sugar bowl has not been served with a carefully calculated diabetic tray to be either laughingly or indignantly refused by the patient according to his sense or lack of sense of humor. Thereafter usually ensues a search for the careless person. The dietitian is absolved, because she didn't set up the tray. The nurse left the setting up of the tray to the ward helper because more pressing duties called her away. It would only be boresome to enumerate the many mistakes that may occur under a system in which responsibility is lacking or at least much divided.

Most hospitals which have outgrown this system, and the number is increasing, have only done so gradually. Although many arguments, usually economic and those related to nurse training have been advanced against it, the fact remains that the responsibility for the preparation of weighed trays and their service to the patient is the dietitian's. The patient is ordered and should

*Read before the dietetic session of the American Hospital Conference, October 29, 1923, Milwaukee, Wis.

have certain definite foods in definite quantities and neither the patient nor his physician should be expected to be satisfied with the dietitian's statement that the foods ordered left her department correctly but were mixed up by the nurses on the floor, or the nurse's statement that she served what was sent by the diet kitchen, in explanation of the fact that the patient did not get what was ordered. The food the patient gets is the important thing, not what left the diet kitchen or was received on the floor. Next, if not equally, important is the charting of the food the patient eats, in order that the physician may intelligently direct and the dietitian follow treatment. This fact is too obvious for dilatation.

Dual responsibility is very rarely and in hospital work almost never successful. Food responsibility, particularly in diabetes, is the dietitian's and she should be insistent that it be given her. She should be insistent with the nursing department or the administration or both until she has been given the opportunity to convince them. This means that the dietetic department will have to do all the work pertaining to weighed trays and includes the service of these trays to the patients and charting on the patients' record.

As was said before, practically all the hospitals which have this single headed control have only gradually come to it. With the first awakening of the consciousness that all was not well, attempts were made to make a tighter tie-up between the nursing and dietetic departments. Tie-up in hospitals usually means more printed forms and these were duly made up, printed, and either forgotten or found to be ineffective, until gradually the administration was forced to realize that the responsibility for this service must be single.

Central Kitchen Service Not Essential

In principle, I am not concerned with the merits of the dietitian's serving weighed trays from a central diet kitchen or preparing them there and reheating and serving them from a sub-kitchen or kitchens. The important fact is to have the dietitian in full charge of these trays, their delivery to the patient, their removal from the bedside in order to weigh the uneaten food and the notation of the values of the eaten food on the patient's chart. The dietitian can be depended upon to exercise enough ingenuity to make her system fit the physical layout of the building.

In approaching the problem, the dietitian would be wise in making haste slowly, and not making undue demands. No new buildings and frequently no alterations of existing facilities are needed to start the work. If the central diet kitchen is too far removed from the wards, a floor diet kitchen can be converted into a sub-kitchen for distribution of the weighed trays. With the co-operation of the administration, diabetic patients can usually be segregated in wards or rooms adjoining this sub-kitchen. Nurses on diet kitchen duty who can be assigned to this weighed tray work as part of their instruction, will have a much better and more sympathetic understanding of the management of these patients subsequently under their care.

It must be understood that the institution of such a service requires an enlarged dietetic personnel depending on the size of the service. The dietetic department, however, is not different from any other hospital department and only with continual supervision can it meet with success. Although opposed in principle to charging for extras, I believe that hospitals unable to undertake any additional financial burdens would be justified, temporarily at least, in charging extra fees for weighed trays and employing additional dietitians in order that their patients may get the weighed trays ordered for them.

Increased knowledge of and use of insulin is giving and undoubtedly will continue to give the dietitian a very splendid opportunity for insistence upon complete and continuous weighed tray supervision and with this supervision she will not need to ask how she may be brought into contact with administrative problems. The organization of a weighed tray service, as has been outlined, and the supervision necessary to maintain its proper everyday functioning with a minimum possibility of error give an opportunity for the exercise of a high order of administrative ability upon the part of the dietitian. To this ability must be added the tact which will permit the service to function in such a way as to avoid friction with the nursing and general administrative departments of the hospital. What has been said in regard to the importance of accurate weighed tray service in relation to diabetes, applies with equal force to other conditions requiring accurate metabolic studies for the advancement of our knowledge of these conditions.

TEN BECOME TYPHOID VICTIMS THROUGH INFECTED EMPLOYEE

Ten cases of typhoid fever were recorded among the employees of a certain hospital in the Borough of Manhattan between October 19 and 31, 1923. The matron, six nurses, one intern, a table helper, and a porter came down with the disease. This number represented about ten per cent of the total number of employees in the institution. It is significant that not a single case occurred among the patients who numbered 100 at that time.

It was evident that the infection was carried along the route of delivery of food to the employees. The carrier was quickly found with the aid of the hospital laboratory and research, New York City department of health. The person infected has for twelve years been an inmate of an institution for the care of mental cases and upon being discharged had sought employment at one hospital and then in the hospital where the infection occurred. The infected man was employed as a bread slicer for the employees, otherwise there would have been cases among patients.

MISS MARLATT SPEAKS AT MEETING OF CHICAGO DIETITIANS

The monthly meeting of the Chicago Dietetic Association was held Friday evening, January 25 at the Cordon Club headquarters, Fine Arts Building, Chicago, Ill. Miss Abby Marlatt, dean of the home economics department, University of Wisconsin, spoke upon her experiences in Europe during the past year.

NEW YORK DIETITIANS MEET

The monthly meeting of the New York Association of Dietitians was held Monday evening December 17, in the Assembly Hall, 610 Lexington Avenue, New York City.

Dr. Dana Atchley, Presbyterian Hospital, was introduced by Mrs. Bryan. Dr. Atchley gave a most comprehensive and instructive talk on diet in cases of hypertension and nephritis. Dr. Mary Schwartz Rose, Columbia University, spoke on the feeding of well children. This talk contained interesting information, as it was based on accurate experimentation.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

STANDARDIZATION OF X-RAY EXPOSURE IDENTIFICATION*

BY EDWARD S BLAINE, M.D., ASSOCIATE PROFESSOR OF ROENTGENOLOGY, NORTHWESTERN UNIVERSITY MEDICAL COLLEGE; CONSULTING ROENTGENOLOGIST, COOK COUNTY HOSPITAL; DIRECTOR X-RAY DEPARTMENT, NATIONAL PATHOLOGICAL LABORATORY, CHICAGO, ILLINOIS.

THE subject of a standard identification of the x-ray exposure, either film or plate, does not appear to have had the attention it deserves in view of its importance in roentgenological work. This observation is the result of a more or less considerable experience in consultation x-ray work, exposure on film and plate from various parts of the country being sent for opinion. These exposures reveal a lamentable lack of proper identification which calls for serious attention. Many roentgenologists, however, have an adequate marking system, and obviously much of what follows will not appeal to them.

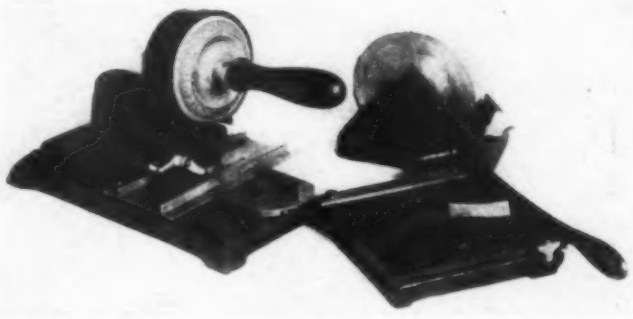

Fig. 1. The stencil machine with special stage for the lead sheeting seen mounted on roll support and the trimming board used to cut down size of stencil.

It is found too common a practice to make exposures without any indelible marking which will give unalterable evidence of several important and vital factors which enter into the identification of any given exposure with any given individual who presents himself for x-ray study. The careful roentgenologist observes a technique that betokens ample care, so that mistakes do not often occur. The use of rubber stamps, gummed labels or other similar procedures cannot be regarded as sufficient, because they are applied *after* the film has been handled by one or more assistants in the laboratory. In some instances, certain exposures have been inadvertently assigned to the wrong patient.

In a few cases, substitution of exposures has been done with intent for one reason or another. This has been established in certain instances; one is the case of a short stout woman of forty-five whose gastro-intestinal tract was examined by someone claiming to be a roentgenologist, who gave her her plates with a diagnosis of a gastric ulcer. She took these to her physician, who was not convinced that the findings were correct, inasmuch as the clinical evidence failed to support them. He therefore asked for an opinion by another roentgenologist on the evidence submitted. At first glance at the plates it is apparent that they are not those of the patient who presented them. She is a stout woman of 140 pounds. Two eleven by fourteen inch plates show a slender narrow waist well within the edges of the plates which were placed lengthwise to the patient. The shadows are those of a slight, slender woman, of approximately 100 pounds, the bone shadows indicating twenty to thirty years of age. The lady took much offense when I informed her that these plates belonged to another, and she countered by showing me the position of the gastric ulcer which the roentgenologist (?) had indicated to her with pen and ink arrow.

Fig. 2. The significance and importance of each of these lines is detailed in the text.

This is but one of several more or less similar instances which need not be detailed, in support of this presentation,

*Read at the Midwinter Meeting of the American Roentgen Ray Society, Atlantic City, N. J., January 26-28, 1922. Reprinted from the April, 1923, issue of The American Journal of Roentgenology and Radium Therapy. Vol. X, No. 4, pages 303-306, Copyright, 1923.

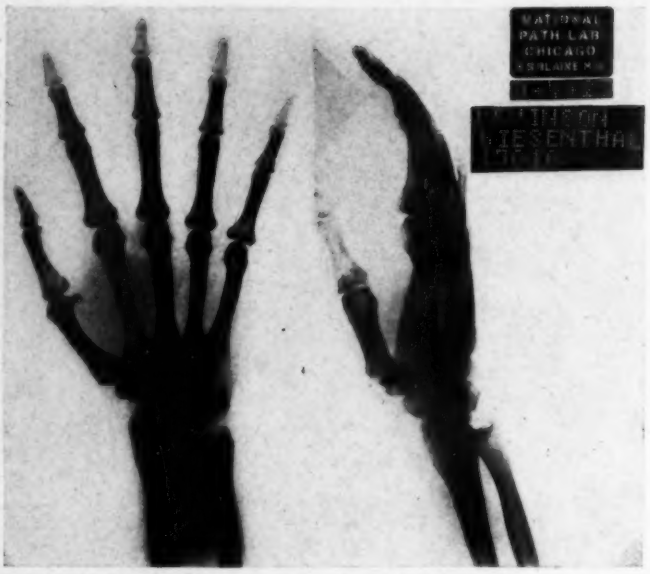

Fig. 3. Example of identification stencil for bone and joint exposures.

the purpose of which is to encourage the adoption of a standard identification which will prevent such intentional as well as unintentional assigning of plates to patients to whom they do not belong.

The accidents of unintentional substitution cannot be condoned, because of the simple manner in which such happenings can be easily avoided. Some roentgen workers use a simple serial marker of opaque figures, which is far better than nothing at all. But here, too, the chances of error are still too high.

It is true that when very few, say, one or two cases a day, are examined, the chances of mistakes in identification of films are small, but if two cases of the same anatomical part are exposed on the same day, the patients being approximately the same size, age, sex, etc., the chances for error are greatly increased. The writer knows of an instance in which this occurred: a renal stone was diagnosed and operated for in one patient, when it really was in the second patient—the exposures being mixed up.

Another factor in exposure identification is that of determining the right and left side of the anatomical part exposed. This cannot always be established when no identification is used. Obviously an opaque "right" or "left" will indicate this if properly placed, but mistakes have often been made in this procedure when the patient lies prone on the plate. Mistakes by clerks, assistants and helpers can be reduced to a minimum, if a standard form of identification be made.

Requisites for Identification

The following requisites are regarded as vital:

First. The identification should, in all instances, be exposed on the plate or film *with the part*—that is, it is a simultaneous exposure of both. It matters little where this identification be placed on the film, due regard being given for the anatomical shadows lest the marker interfere with the results, but unless contraindicated, it should routinely be placed in the upper right-hand corner.

Second. The marker should always be placed right side up, i. e., faced toward the tube target, whether the plate be horizontal, vertical or in any other position. If no exceptions be made to this rule, one can determine rights and lefts without other special marking. Thus the need of placing an opaque "R" or "L," or the word "right" or "left" can be properly dispensed with. This is regarded as particularly valuable in double-coated film exposures. Anteroposterior, posteroanterior and other direction of x-ray passage will also be evident if this procedure be used as a standard. The "front" or "face" of double-coated exposures is automatically established with 100 per cent definiteness.

Third. The identification should give the following indelible information, as illustrated in Figure 1:

1. Name of hospital or other institution in which the exposure is made. If not a diagnostic institution, this item is not necessary.
2. City in which the hospital is located. This is to distinguish one hospital from another of similar name, as, for instance, St. Lukes of New York from St. Lukes of Chicago.
3. Name of doctor-roentgenologist who is in charge of the x-ray department, and who is responsible for the x-ray work and diagnosis.
4. The date on which the exposure is made. This is of prime importance when following the progress of a given case, for comparisons in medicolegal cases, etc.
5. The name of the patient (usually the last name suffices). Some names (particularly foreign names) are of such length that the marker would have to be of considerable length; in such cases it can be shortened so as to give unmistakable letters establishing the particular patient exposed.
6. The name of the referring physician.
7. The serial number of the cases. (This is optional, but very convenient for office records, etc.)

There are several ways in which this identification can be done. A convenient way is to have a lead stencil made

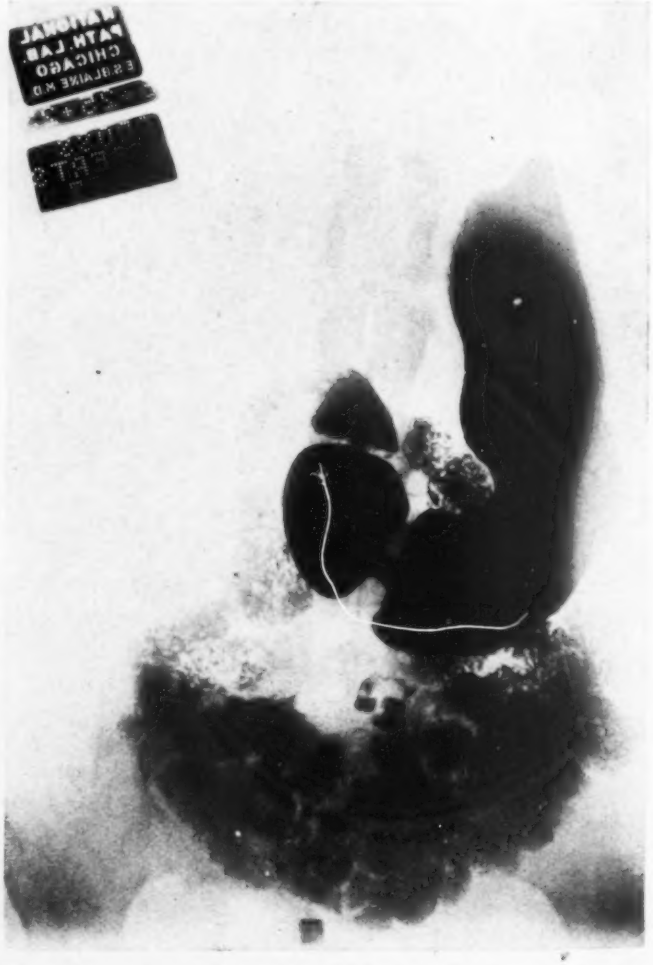

Fig. 4. Example of identification of gastro-intestinal exposures. (Illustration is reversed showing film viewed from behind.)

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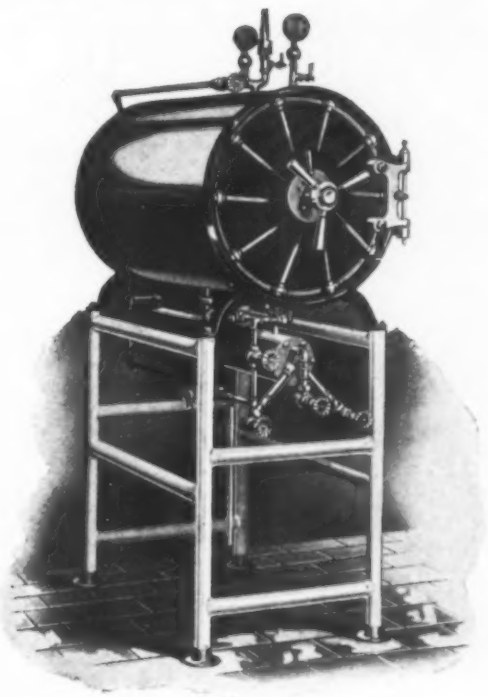
The Castle dressing sterilizer is always dependable. It is simple. The operator knows what she is doing, and why. It is so different in principle than any other that it will pay you to ask for our "Analysis of Dressing Sterilization".



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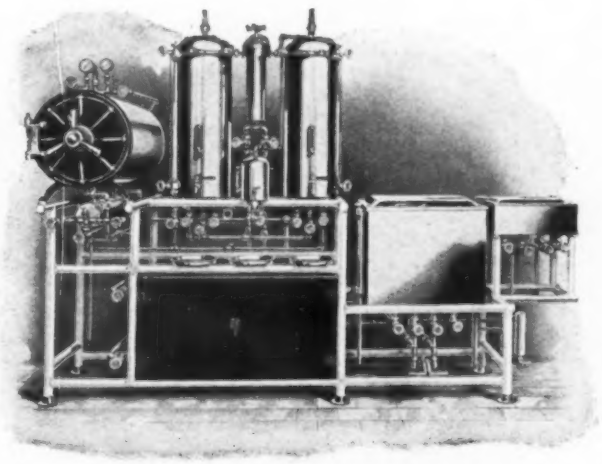

Of course we make complete units. This one was built for St. Mary's Hospital, Syracuse, New York.

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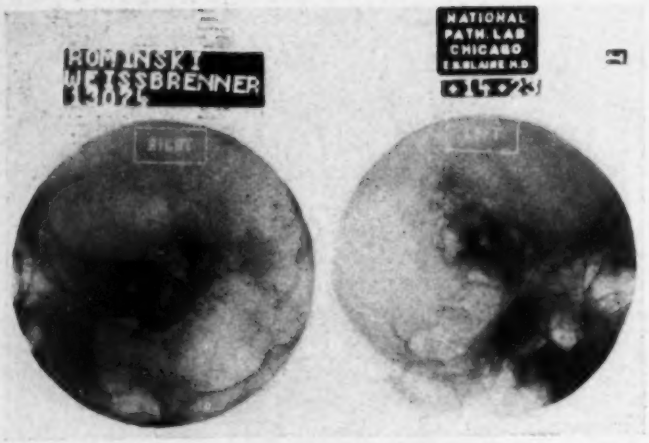

Fig. 5. Example of identification of mastoid exposures using double or border exposures.

for those portions which are never changed, namely, the hospital or laboratory, the city and the roentgenologist's name. The date can be set up with small lead figures, placed on adhesive plaster, this being done but once a day. The other features, likewise, may be set up on adhesive plaster, using lead letters and figures. If many patients are examined, there is much delay in setting up all this information letter by letter and figure by figure; on this account one is loath to give the necessary time to the procedure. A search was made for a stencil machine which would provide this opaque marker quickly and easily. The one illustrated in Figure 1 has been found to give full satisfaction, and the stencil is quickly made. An alphabet and numerals provide all letters and figures. The stencil material used is the lead sheeting used in backing dental x-ray films. It can be obtained in eight-pound rolls at a small cost. A roll of the material can be mounted on a suitable wooden axle support (easily constructed by the average technician) so that the heavy material can be reeled off in any length. A small photo trimming board is used to cut this material into three-inch pieces; small-sized tinners' snips are also convenient. This stencil machine is equipped with a platform or stage built especially for the writer to accommodate this particular strip lead. Five separate lines of any length can be stenciled. After stenciling the marker, it is trimmed down to the smallest size possible so as to occupy a minimum of space on the exposure. This is invariably less than two by three inches in area. The time needed to make a complete stencil averages one minute. Figure 1 illustrates the stencil-performer machine and the several parts used.

In Figure 5 is seen the appearance of this form of exposure identification. An exception is made in this technique as applied to the exposures of the mastoid of the head where border exposures add materially to the appearance of the film, as illustrated in Figure 5. In these cases the marker is exposed while exposing the border, which is always done immediately after each anatomical exposure.

In justice to every patient, and in all fairness to the roentgen practice, the essayist believes that all exposures should be marked inerasably and indelibly, which will always prevent mistakes of assignment and preclude the possibility of substitution. Such identification as is here described can never be mistaken and films so marked can never be used for anyone else.

From the medicolegal standpoint, this form of identification is especially valuable, and of utmost importance, and the hope is here expressed that in the not far distant future every x-ray film or plate exposure placed in evidence in court procedure will be *required by law* to have unalterable and unmistakable identification along the lines herein set forth.

RECOMMENDATIONS FOR HANDLING AND STORING X-RAY FILMS

During the past year or two the storing of x-ray films has become a problem to many hospitals where a large number of films accumulate. These films are not so inflammable as sometimes believed, for they are coated with a solution of gelatine and silver salt which reduces the rate of burning in case of fire.

However, too great care cannot be exercised in the storing of x-ray films if they are to be satisfactorily preserved. A company which has made a thorough study of films of all types and has had long experience in storing of films makes the following recommendations for the storing of x-ray films in hospitals. The results of a practical survey by this company in a number of cities show that the adoption of these specifications which take away the hazard involved in the storing of the present type of x-ray films is considerably less than the extra cost involved were cellulose acetate films adopted.

(1) In all rooms where x-ray films are stocked, handled or filed, smoking should be strictly prohibited and conspicuous "NO SMOKING" signs posted.

(2) A metal can (preferably with spring hinged cover) should be provided for all waste negatives and film scrap, and at no time should these be permitted to accumulate and lie around on tables, benches or floor.

(3) It is best, both for the matter of freshness of films and reducing fire hazard, that the stock of unexposed films should be kept at a minimum—the actual quantity depending on the ease of receiving fresh supplies from the dealer or distributor. Such stock should be kept in a cool, dry place out of the way of ordinary room traffic, in a metal box or can. A lead-lined metal box or can is suggested, as this also prevents damage by x-rays.

(4) In rooms where films are filed or handled there should be no flames or any other than standard electrical fixtures. All open lamp bulbs should be protected from breakage by suitable guards. A hand fire-extinguisher should be in each room where films are handled. Any of the standard approved portable two and one-half gallon extinguishers will be satisfactory. Darkroom and other doors should be arranged so as to make egress from such rooms easy. It is desirable, if possible, to have such rooms protected by automatic sprinklers.

(5) Film negatives should be filed as soon as possible in heavy manila envelopes, either singly or by case, and the filing of these so arranged that it is convenient, from time to time, to weed out useless negatives.

(6) Illuminators should be so designed that the diffusing glass is not hot to the touch and there should be no unnecessary display of film negatives in lighted illuminators. Negatives sent up for viewing should be confined to those actually being inspected.

(7) If it is necessary to keep an active file of films for a current period of about a week in the actual x-ray room, these should be kept in a metal container. Such a file should be limited to about fifty pounds of films.

Where it is necessary to keep the accumulated results of x-ray examinations for a period of months or years, it is obviously necessary to take certain further precautions to reduce fire hazard. In the case of hospitals, where it is usually possible to secure additional space for such a purpose, a suitable room should be set

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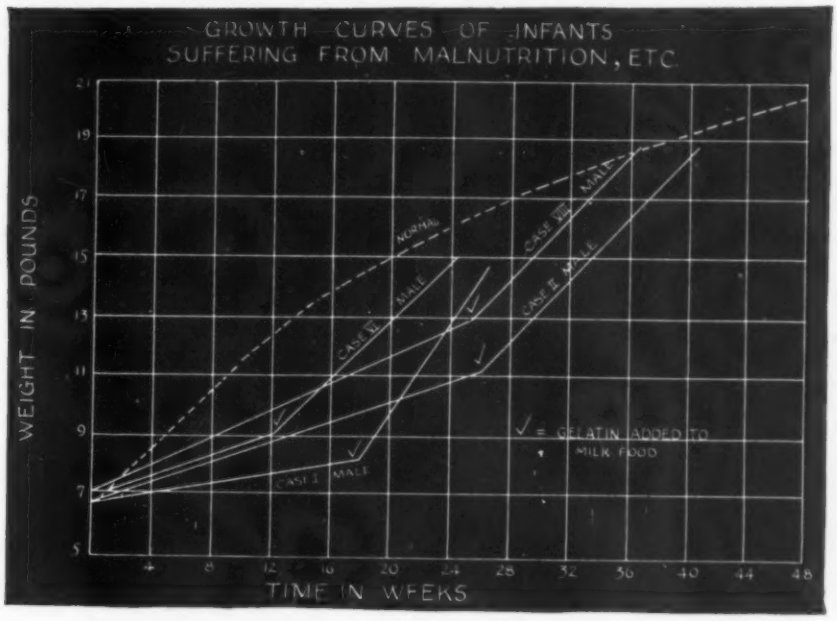
The Value of "Gelatinized" Milk in Mal-Nutrition



HERE is an exact chart showing the growth curves of four infants suffering from malnutrition, resulting from imperfect assimilation of the milk nutriment—the most valuable of all foods.

Note the sharp angle of recovery after plain edible gelatine was added to the milk formulae. The colloidal action of the gelatine prevented excessive stomach curding of the milk and insured the proper absorption of all the milk nutriment, besides supplying the Amino-Acid, Lysine, essential to healthy growth.

Gelatinization of the milk does not interfere in any way with any formula prescribed by the physician, but does, on the other hand, greatly augment the efficacy of every milk diet whether for infant or adult.

That Gelatinized Milk is one of the most important advances in dietary practice has been fully demonstrated, not only for infants, but also in all child and adult cases where impaired digestion prevents perfect nutritive assimilation. The only precaution necessary is to use a pure unflavored, unsweetened, granulated gelatine, of which the highest known standard is

KNOX
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"The Highest Quality for Health"

For the Perfect Gelatinization of Milk

Put one tablespoonful of gelatine in ½ cup of cold milk and let it soak for 10 minutes. Place the cup in boiling water, stirring until gelatine is fully dissolved; then add this dissolved gelatine to the quart of cold milk or regular formula, from which you have taken the original ½ cupful.

In addition to the family size package, Knox Sparkling Gelatine is put up in 1 and 5 pound cartons for special hospital use. A trial package at 80c the pound will be sent on request.

Charles B. Knox Gelatine Co., Inc.
400 Knox Ave. Johnstown, N. Y.

aside for an exclusive and permanent bulk file of all x-ray negatives. Such a room should preferably be located at the top of the building and be of fireproof construction. Most modern hospitals have small rooms which could be made into virtually fireproof vaults by a few simple changes. There are only three basic requirements that should be satisfied:

(1) The room must have a direct outlet to the outer air.

(2) There should be a Class B, self-closing fire door at communication to building proper.

(3) The room should be additionally protected by automatic sprinkler heads operated from an adequate water supply.

As regards the vent, this may be kept covered against the weather by one-sixteenth inch glass. If the room is not located on the top floor it is desirable, in cost cases, to run a metal vent pipe from the outlet to the roof. The exact size of the vent depends upon the number of pounds of negatives stored, and can be determined from the basic requirements that for each 1,000 pounds of film stock there should be 140 square inches of vent. Thus

A circular opening of 13½" diameter for 1,000 lbs.
A circular opening of 9½" diameter for 500 lbs.
A circular opening of 6¾" diameter for 250 lbs.

As a guide in figuring poundage of stock the following table is useful:

1,000—14x17 negatives weigh approximately 118 lbs.
1,000—10x12 negatives weigh approximately 60 lbs.
1,000— 8x10 negatives weigh approximately 40 lbs.
(Other sizes in proportion to area)

Relative to sprinkler protection, if there is no existing independent sprinkler water supply available it will in a great many cases be acceptable to attach the film room sprinkler to the existing house water supply.

(1) As to walls, where structural changes are necessary or it is convenient to partition off a small part of an existing room, such partitions can be satisfactorily made of hollow tile and cement plaster—the entire wall thickness of necessity being not over three inches.

(2) In case such a room is not available and the quantity of films does not exceed a reasonable amount, reduction of the fire hazard is assured by the use of proper metal cabinets. These cabinets should correspond to the "B" or "C" label metal safes and be vented to the outside by metal pipes. Suitable safes of this type will shortly be available. The quantity of films which can be stored in such a manner is limited to 500 pounds in one safe and 1,000 pounds in two safes in any one room. A safe of practical dimensions, however, (such as the one in course of manufacture), will not conveniently hold much more than 250 pounds of film negatives in envelopes. If reduction of fire hazard only is desired, this type of safe will generally be suitable, but if it is also desirable to save as many negatives as possible in case of a fire, the addition of a suitable sprinkler head in the top of the cabinet is necessary. If a safe containing more than 250 pounds of films is used it should be divided into two compartments—each properly vented. In case of fire and the flooding of the contents from the sprinkler head, it is possible afterwards to reclaim most of the negatives which are merely wet by soaking them in water as soon as possible. The sprinkler protected safe is the preferable system. In these safes and also in the virtually fireproof rooms previously mentioned, any convenient filing arrangement of films in envelopes may be used.

(3) The attendant expense of setting aside a virtually fireproof room or securing a suitable metal cabinet is merely a nominal one and will be, in the case of even large consumers of films, the final one. These suggestions have been carried out by a number of large users of x-ray films with adequate experience both as to the matter of safety of negatives and relations with underwriter bodies, and in no instance has the attendant cost been considered excessive, especially when considering the efficiency of films as radiographic records both in buying and handling.

A WOOLEN PNEUMONIA JACKET

A garment which aroused considerable interest at the recent exposition of the American Hospital Association was a pneumonia jacket made of a mixed wool blanket material. It contains twenty per cent to thirty per cent of wool, assuring maximum warmth with minimum weight. This combination of wool and cotton permits the garments to be washed frequently yet reduces to a minimum the amount of shrinking. It is especially well made with double felled seams, has a very novel arrangement of pleats and tucks so that only two sizes are necessary, one for children and one for adults.

The patient in the picture is wearing the woolen pneumonia jacket.

HOSPITAL-TYPE PLASTER INTERCEPTOR FOR PROTECTING PIPES

Hospital people are familiar with "plaster sinks" and other methods of preventing plaster of paris, bits of bandages, lint, hair and other solid matter from entering the waste line drains of plaster rooms and dressing rooms.

An interesting improvement on old methods is the recent development of a hospital-type plaster interceptor, illustrated here in cross section showing interior construction.

The interior construction of the interceptor is of aluminum with brass screens and is practically acid proof. The screens are in slots and easily removed for cleaning. The baffling construction is such that, irrespective of the vol-

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A favorite Jell-O dessert from the Hotel Pennsylvania menu.

JELL-O FRUIT CUP

Cut up any fruit in season, place in glass, and pour any flavor of Jell-O when cold but still in liquid. When jelled, top with whipped cream and decorate with maraschino cherries.

Hotel Pennsylvania
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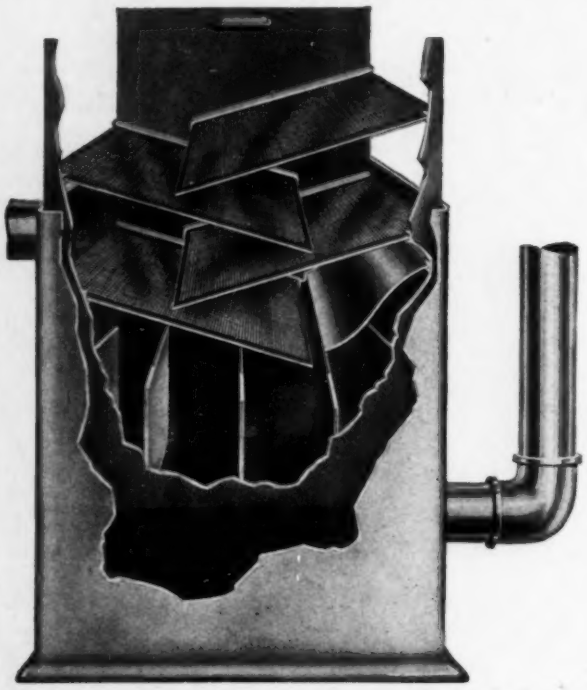
The Jell-O dishes on the Hotel Pennsylvania menus are always popular and always profitable. The hotel chefs, in preparing these Jell-O salads and desserts, use the Institutional Package, the big box for big users. A little suggestion in this for other hotels and restaurants. You'll admit the Hotel Pennsylvania knows good food and good business.

Genesee Pure Food Company

LE ROY, NEW YORK BRIDGEBURG, ONT.

ume of water flowing through the device, the heavy solids are not disturbed, and all matter in suspension is filtered through the heavy screens, thus insuring that the waste line beyond this device cannot become clogged.

The hospital-type device is sixteen inches high and fourteen inches square, made of cast gray iron, white enameled



inside and out, all exposed metal parts being highly nickeled. The interior construction is easily accessible for cleaning, and the manufacturer calls attention to the important fact that this interceptor is entirely non-syphoning.

NEW X-RAY TUBE MAY DECREASE COST OF CANCER TREATMENT

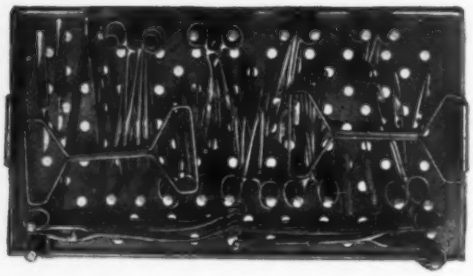
Considerable publicity has been given recently to a report that a new and much more powerful type of x-ray tube had been produced by a well known manufacturer of electrical supplies, and was in successful employment at St. Luke's Hospital, New York. We therefore asked Dr. Francis Carter Wood to make a short report on the matter. His report is as follows:

The new x-ray tubes with which we have been experimenting at St. Luke's Hospital are not new in principle, but have only certain modifications which enable them to be used at the usual voltages of from 170,000 to 200,000, and at the same time carry a very much larger quantity of current than the standard Coolidge tube. They have one great advantage in that they are not water-cooled. At the lower voltages these tubes are protected by the regular lead-glass bowls, at the higher, immersed in lead lined oil tanks. So far no thorough life tests are available, though one tube has run for about 500 hours and is still in perfect condition. The especial advantage of these tubes is that they easily carry from ten to twenty milliamperes at 170,000 to 200,000 volts. This greatly increases the amount of x-ray which they yield. The large anticathodal surface also seems to catch a larger number of electrons, for the tubes give some twenty per cent more x-ray than the standard tube at the same voltage and milliamperage.

The importance of all this is not that the rays given out are any more effective in the treatment of cancer, but only that the larger yield permits a great shortening of the necessary exposure, and thus saves time both on the part of the patient and on the part of the attending staff. If these tubes come on the market, therefore, they will greatly extend the range of usefulness of x-ray in the treatment of cancer. With the present high cost of tubes, it is difficult to treat poor people unless the radiotherapeutic clinic is endowed. This high cost of treatment is largely due to the short life of the very expensive Coolidge tubes. Should these new tubes have the long life and the high efficiency which it seems justified to hope from the early experimental results a distinct step forward in the treatment of inoperable cancer will have been made.

INSTRUMENT STERILIZER TRAY

An instrument sterilizer tray has recently been designed by a member of the Fifth Avenue Hospital, New York, N. Y., for use in that hospital. This tray is of particular value as a part of the equipment of every



hospital because it serves as a time economizer and is a means of protection for surgical instruments.

In using this tray it is possible for the nurse to assort the instruments that are to be used, arrange them on the tray, before immersing them in the sterilizer. After sterilizing has been completed, the tray with the instruments is lifted from the sterilizer and placed upon the instrument stand ready for use.

The tray illustrated is manufactured of a highly selected grade of metal heavily nickel-plated and is made to fit into a twelve by twenty-two sterilizer.

RUBBER STAIR TREAD

One of the first places to register wear and tear in the hospital is the stairway, particularly where its use is not entirely replaced by elevators. Stairs which are subject to constant usage need to be protected or they soon require a covering to conceal their unsightliness.

A heavy rubber tread adapted for covering stairs which are badly worn is now on the market. These stair treads are made in both round and square nosing and where the step is badly worn such as marble or wood, the worn places can be filled in with felt so as to make a smooth covering. The tread has the advantage of eliminating noise, and of saving the wear and tear on the feet as well as on the stairs.

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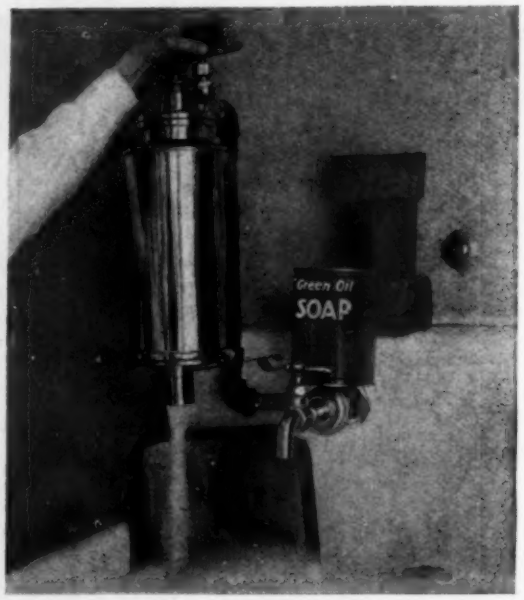
NEW SOAP AND WATER MIXER

Hospitals interested in the conservation of soap and also in obtaining, without difficulty, different strengths of suds will welcome the new automatic soap and water mixer which was demonstrated at the A. H. A. exposition last fall.

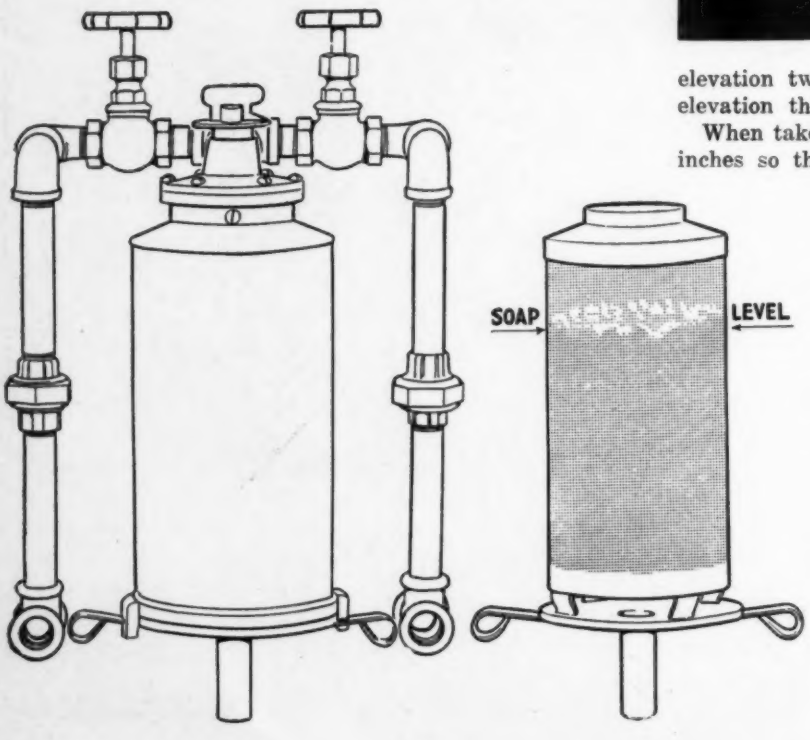
This mechanical device was invented for the purpose of



taking any kind of soap and, by a series of different sprays having a different velocity of pressure, produce four different strengths of suds. The two brass discs seen in the picture revolve against each other and the pressure of the water back of the top disc prevents any leakage when the holes are not open. When the water is shut off all the water that has been on the soap is turned off, leaving the soap dry in the mixer.

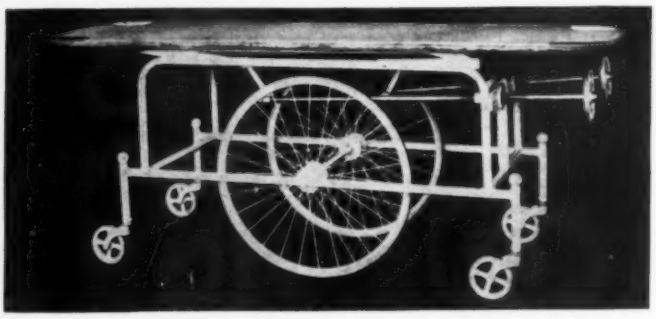
An important feature of the device is that the key which turns the discs to get the different strengths of suds can be removed and this automatically locks the machine so that only one strength of suds is produced, according to the setting of the dial. When the dial is set to give a definite strength of suds the operator can get less solution by not turning the water on full force. This the solution can be regulated from a weak strength up to the full strength at which the dial is set.

The mixer is made of copper and brass with a container that holds the soap made of non-rusting metal. It comes in three sizes, one holding ten pounds; one, five pounds; another, two pounds. The smallest mixer is arranged with spray openings of the proper intensity to make automatically enema soap solutions. The mixer is adjustable to hot, cold, hard or soft water, to any pressure back of the main. Where the mixer has been installed it has been found to regulate the strength of suds so that marble and tile floors can be cleaned properly and not leave soap on the floors to make them slippery. The experience of two hospitals shows that surgical green soap can be used successfully in this mixer with less expense for scrubbing floors, dishwashing and general cleaning than can laundry soaps. The record of four hospitals which are using it shows that a saving of fifty per cent in soap is effected by its use.



ADJUSTABLE WHEEL STRETCHER

An adjustable wheel stretcher which can be lowered and raised to facilitate the handling of the patient has recently been placed on the market. This stretcher has a metal top and a one inch bumper all around. It is seventy-two inches long and twenty-two inches wide, with low



elevation twenty-eight inches from the ground and high elevation thirty-six inches high.

When taken to the bedside, it is lowered to twenty-eight inches so that the patient can be removed from bed to stretcher with the greatest ease. When taken to the operating room it is quickly elevated to the height of the operating table by hand controls at head end of stretcher. The stretcher not only can be raised vertically but also in Trendelenburg and reverse Trendelenburg positions which may be quickly obtained by the wheel controls, as shown in the illustration. This facilitates the performance of many minor operations on the stretcher. The adjustable features also make it ideal for x-ray work and when so used a wooden top is furnished. The top of the stretcher may be removed and used as a carrying stretcher.

The stretcher will turn in its own length, being pivoted on the large center wheels, which thing is often a great advantage in narrow hallways.

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DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

NEW YORK PUBLIC WELFARE DEPARTMENT ADOPTS STANDARDIZED DISPENSARY FORMS

DURING the spring of 1923 a big step forward was taken in the matter of hospital record keeping in New York City. The superintendents of those hospitals in the department of public welfare having out-patient departments met and discussed the systematization of dispensary record keeping, the standardization of the record forms to be used, and the placing of the administrative operations on the simplest practical working basis to meet the requirements of the state law, state board of charities, associated out-patient clinics and department of public welfare.

It was concluded that a central filing system was best; that all the clinical records of a patient should be kept together in an envelope and these filed numerically; and that the identification or index card (containing all social data and information) should be filed alphabetically.

The following forms were agreed upon:

(1) Patient's pass card (or admission card).
(2) Identification card (or index card).
(3) Envelope for record.
(4) Face sheet of history.
(5) Continuation sheet of history.
(6) Out and in form.
(7) Refer and transfer form.

These forms were to be identical for all the dispensaries in the department and were to contain only what was deemed essential. They were shown in a display at the booth of the Associated Out-Patient Clinics of New York in the recent exhibition of the American Hospital Association at Milwaukee.

(Admission Card)

City of New York
DEPARTMENT OF PUBLIC WELFARE

..... *Hospital*

OUT-PATIENT DEPARTMENT

..... *Clinic*

Name..... *No*.....

Address..... *Age*.....

NO TREATMENT WITHOUT THIS CARD

This system, besides accomplishing the purposes set forth in the opening paragraphs of this article, is advantageous in that it enables the physician to obtain easily

(Index Card)

City of New York
DEPARTMENT OF PUBLIC WELFARE

..... *Hospital*

OUT-PATIENT DEPARTMENT

Name..... *No*.....
Address..... *Age*.....
Occupation..... *Color*..... *Sex*.....
Are you able to pay for the services of a physician?.....
Remarks .....
.....
Date..... *Clinic*.....

(History Envelope)

Name..... *Number*.....

City of New York
DEPARTMENT OF PUBLIC WELFARE

..... *Hospital Out-Patient Department*

City of New York
DEPARTMENT OF PUBLIC WELFARE

..... *Hospital*

Diagnosis .....
.....
Name..... *No*.....
Address..... *Age*.....
Occupation..... *S.M.W.*.....
.....

(History Face Sheet)

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City of New York
DEPARTMENT OF PUBLIC WELFARE

Name..... ..... *No*.....

.....

(History—Continuation Sheet)

the history and account of previous treatments of patients coming to him from another clinic of the dispensary; it allows, upon admission of a dispensary patient to the hospital, for the incorporation of the dispensary

(For outer-clinic use)

City of New York
DEPARTMENT OF PUBLIC WELFARE

.... *Hospital*

Name..... *No*.....

Address..... *Age*.....

From .....*Clinic*

To .....*Clinic*

Request consultation
Transfer

.....
Clinical Physician

record in the hospital record, so that it may become a permanent part thereof; and it reduces materially the total number and kinds of forms used and effects a great saving in the cost of printing.

(For transfer between hospital and clinic)
City of New York
DEPARTMENT OF PUBLIC WELFARE
..... *Hospital*
FOR OUT-PATIENT REFERENCE

Name of patient..... *Hospital No*.....

Date of admission..... *Date of discharge*.....

Principal diagnosis .....

Complication .....

Operation .....

Recommendations for further treatment.....

.....

Signed....., *Intern.*

..... *Hospital*
FOR IN-PATIENT REFERENCE

Name of patient..... *Disp. No*.....

Age..... *Address*.....

From .....*Clinic*

To .....*Service*

(For admission to hospital)

Principal diagnosis .....

Remarks .....

.....

Signed.....
Disp. Physician

EDUCATING PATIENTS AT CLINICS FOR VENEREAL DISEASE

TREATMENT OF THE VENEREAL DISEASE PATIENT. By H. E. Kleinschmidt, M.D.

Those who come to clinics for venereal disease to seek relief are for the most part persons who perhaps have suffered deep remorse because of a misstep and are keenly responsive to any method which will assist in combating venereal disease as a social evil. The male patient, after his unfortunate experience, will be more than willing so to instruct his sons, if he has them, that they shall not fall into the same trap. The young woman who has suffered a bitter personal experience because of previous ignorance of venereal disease can easily be made a propagandist of social hygiene. In the clinic, then, is a select group which should be educated to the end that information concerning the spread of venereal disease may be widely disseminated. Unless the clinic is kept on a high moral and social plane, this important objective will not be achieved.

OHIO HOSPITAL OFFERS EXTENSIVE CLINIC SERVICE

The City Hospital, Akron, Ohio, now offers an extensive free clinic service as follows: orthopedic, (for crippled children) Wednesday afternoons from 1 to 2 p. m.; prenatal (maternity) Tuesday and Friday afternoons from 2 to 3 p. m., and Thursday from 7 to 8 p. m.; genito-urinary (for urological and social diseases) Tuesday, Thursday and Saturday from 4:30 to 6 p. m.; medical, Tuesday, Thursday, Saturday, from 10:30 to 11:30 a. m. A diagnostic clinic for pay patients is also held on Monday, Wednesday and Friday from 10 a. m. to 12 m. Patients are received to this clinic by appointment only.

According to reports from the hospital, the number of patients cared for in the various clinics of the hospital is gradually increasing with each time that the clinics are held. Up to the present time, a large number of persons has received either treatment, diagnosis, or professional advice at the clinics. In a number of the clinic cases patients receive not only free medical advice and service, but also are supplied with the necessary medicine for their case free of charge or through the hospital drug room, at cost.

ST. PAUL HOLDS FOURTH ANNUAL CLINIC WEEK

The fourth annual St. Paul, Minn., Clinic Week was held from January 15 to 18, 1924. Clinics were held at various hospitals each morning during the session. The afternoons were devoted to the following symposiums: January 15, "Intestinal Obstruction"; January 16, "Life Insurance"; January 17, "Irregularities of the Heart"; January 18, "Etiology and Diagnosis of Diseases of the Kidney and Ureter; also a diagnostic clinic on diseases of the prostate, by Dr. William F. Braasch, Rochester. Thursday evening, January 17, Dr. George E. Shambaugh, Chicago, Ill., addressed the assembly at the annual banquet of the Minnesota Academy of Ophthalmology and Otolaryngology.

You hoard not health for your own private use,
But on the public spend the rich produce.
—Dryden.

Have mind upon your health.—Shakespeare.—Julius Caesar.

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OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and MRS. CARL HENRY DAVIS
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY AND POST-HOSPITAL EMPLOYMENT*

BY SUSAN C. JOHNSON, NEW YORK, N. Y.

PRESCRIBED occupation needs no defense today; its value as a therapeutic agent within certain fields is generally recognized. But its rapid growth and extension into fields other than its original one within the last ten years or so has brought about considerable discussion, differences of opinion and some confusion regarding its value. This seems to be due, in part at least, to a failure to recognize that occupation for the sick is not always directly therapeutic in purpose, and to the loose and inaccurate use of the terms "occupational therapy" and "vocational therapy" or such other terms as refer to the pre-industrial training. An analysis of the problem with some eliminations may clear up some of this confusion.

Although the theory of the work-cure is easily understood, its practical application is not so simple, especially when considered for our large general hospitals of a public or semi-public nature where patients suffer from many different kinds of illness and where the social and industrial problems press closely upon the therapeutic ones. In fact, it is just this overlapping of the several needs of the individual patient which makes any singleness of purpose difficult to isolate and pursue.

Treatment—Primary Purpose

When occupational therapy was confined to hospitals for the insane, we heard very little about it. It had its modest place as a simple but potent form of treatment and most alienists accepted it as such. And, when its use was extended into the closely related field of nervous diseases, it was accepted by neurologists at its face value without much ado. Within these two divisions of the field of medicine, it has today a useful, tranquil and reputable place as a therapeutic agent without any demand that it should also educate or re-educate for industrial placement. The patient may earn money by the sale of his products or he might follow as a vocation something which he had learned to do while in the hospital, but either would be merely incidental to the primary purpose—treatment.

The other division of the field in which prescribed occupation may have primary therapeutic value is in the treatment of orthopoedic cases. There are a number of examples here and there, notably at Walter Reed Hospital, Washington, D. C., where occupational therapy is definitely and specifically prescribed as a form of physical treatment where joints and muscles are involved. Its usefulness in this way is limited at present and its possibilities undetermined. This is probably due more to the scarcity of occupational therapy aides who are qualified for this work than to the failure of orthopoedic physicians to recognize its possibilities.

I cannot agree, however, with the public statement recently made by a physician—not an orthopedist—that occupational therapy aides "fool themselves" into thinking they are benefitting the patient when they know nothing about it. These aides are not so grossly ignorant or so insincere as this would imply.

What Is Required of the Aide

Not only must the aide have a wide knowledge of the kinds and the uses of tools, but she must couple this with a full knowledge of anatomy and physiology and have had training in the practice of adapting the use of tools to fulfill the need for exercise as prescribed, if she is to be truly an aide to the physician in carrying on this branch of occupational therapy.

In general hospitals where there are occupational therapy departments, it is more likely that the duties of the aide are necessarily too general and that she herself realizes the need for special training and special practice for orthopedic work, than that she tries to "fool" herself or others.

When we consider that a hammer may be so small as to be used by attaching it to one finger and so large that its use brings into action the muscles of the arm, shoulder, back, chest and abdomen, that there are numerous sizes and kinds of hammers besides these two and that a hammer is only one of the many tools and appliances used in mechanical work, we realize the almost limitless range of exercise which may be given through their use. Also this use of tools for prescribed exercises may have some advantage over other forms of mechanotherapy, as it centers the patient's attention on things other than his ailment while he is producing some article of interest to him; and so brings about the more natural involuntary movements under a favorable psychology. While this form of prescribed occupational therapy is primarily therapeutic in purpose, it is obviously so closely connected with industrial training that it becomes a very important first step in industrial rehabilitation.

I doubt if the term "occupational therapy" is used exactly when applied to work provided for the feeble-minded. Is it not that it is a particular form of edu-

*Address delivered at the fourteenth annual New York City Conference of Charities and Correction.

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cation with this group rather than a cure.

The feeble-minded, we know, are educated more effectively by manual processes than by intellectual ones and when the mental status is elevated, naturally, the ailment of being feeble-minded is decreased accordingly. Thus, the primary purpose here, in contrast to other forms of mental and nervous diseases, becomes educational and any therapeutic result is incidental. If this be so, the practice here should be based upon principles of industrial education instead of those of therapeutics. In tuberculosis sanatoriums and with many young adults, among the chronic sick particularly, it will also be more rational to consider the primary purpose of prescribed occupation to be academic or industrial education.

Directed Occupation as Amusement

Among all diseases there will be found patients who will find comfort from directed occupation given as a form of amusement but with whom we would not expect it to be of material help in bringing about a cure. Any wholesome amusement which leads to self-activity instead of passivity may have a beneficial effect upon the patient's mind and habits, but whatever value lies therein, is probably more social than therapeutic. Also, there are those patients who have reached a stationary stage and for whom it would be foolish to claim a curative value for occupation. With these cases occupational therapy may have social, educational and industrial value, but the use of the term "occupational therapy" here is misleading.

The cost of maintaining occupational therapy is, without doubt, a legitimate charge against the treatment of patients in hospitals for the insane, for nervous diseases and orthopedic cases. With groups for whom the purpose is improvement in the social condition, the term "therapy" should not be applied nor the cost charged against treatment. Where the primary purpose is to provide pre-industrial or other educational training for the sick, and those who are otherwise handicapped, it would seem to be a just claim against the public funds set aside for education and vocational training. If occupational therapy be considered only as a division of prescribed occupation and the term applied only when the primary purpose is definitely therapeutic, then it will be relieved from a burden which it was never intended that it should carry and also of some ill-repute which has fallen upon it because of this lack of analysis of purpose. Also, a clearer understanding of purpose should open the way for a more equitable distribution of cost of maintenance and a recognition of the need for a different training and different personal qualifications for occupational therapists than for teachers of industrial education for the sick and afflicted.

Post-Hospital Work Shops Needed

The very nature of occupational therapy connects it with industrial rehabilitation, though no sharp line where therapy ends and industry begins can be drawn. Instead, the two should be merged by the middle link of the curative workshop or industrial clinic where the occupation is industrial in character and the instruction is based upon educational principles but where the health of the patient is of first importance. From these curative workshops many patients will pass directly into established industries as they exist, but others must be placed in "sheltered" industries. These sheltered industries, though managed on a thoroughly business basis, will recognize the right of the sub-standard worker to do as much as he is able, even though he will never reach the standard mark for skill or endurance, and will place him upon the payroll for what he can earn, be it much or little.

It is hardly necessary to recall the fact that patients when discharged from hospitals and sanatoriums are still in need of care and that there is more usually than not, a post-hospital period in which the patient is unfit to assume industrial activity under conditions as they exist. We know how the tuberculous patient and the cardiac patient undertake to earn a livelihood under the present working conditions and break again under the strain; how so often it is impossible for the disabled to overcome ordinary traffic difficulties, the crush of crowds, stairways, etc.; how the patient with tremor, imperfect co-ordination, facial distortions, speech defects, epilepsy, and other such disabilities cannot even get a hearing from the average employer, much less a place to work, and how others, too weak or sick to compete within normal industry, are debarred from doing anything because they are unable to keep up to the hours and production demanded. Or, how they must spend with a prodigal hand the energy and strength stored up in convalescent home or sanatorium until they are no more. It is for these that we need the sheltered industry.

Both the industrial clinics and the sheltered industries should take cognizance of both the man and the woman who will never be fit to enter the highly skilled industries. There is need of providing simple industries for persons of lesser ability.

Such industries as needlework of all kinds, commercial embroidery, hand and machine; small carpentry and furniture repair including upholstery and chair seating of the several kinds; book binding; shoe repairing, hand and machine; multigraphing, printing and other commercial work, suggest themselves as occupations involving simple processes and requiring modest outlays for equipment.

Not until we have a complete plan in operation which begins with occupational therapy and leads through curative workshops to established industry which will include sheltered industries, can we hope to give the sub-standard worker his dues, nor make much progress with industrial rehabilitation for the sick and otherwise handicapped person.

OCCUPATIONAL THERAPY IN A SMALL PRIVATE SANATORIUM

By AMY F. BAKER, Head, Occupational Therapy Department, Rosedale, New Rochelle, N. Y.

Occupational therapy is rapidly spreading to small sanatoriums and private homes for the care of slight nervous and mental cases. A small private sanatorium which is making progress in its development of occupational therapy work is Rosedale, a private sanatorium for nervous and mental cases, New Rochelle, N. Y. The work was organized a year ago at the request of a few

View of the main house from the garden.

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Eastern entrance showing occupational therapy department.

specialists who have patients in that institution.

The progress of occupational therapy work in this sanatorium is of particular interest because of the informal, home-like atmosphere which pervades the institution. The sanatorium consists of a large roomy house and two small cottages situated nearby. The grounds cover five acres, formerly an old private estate.

Doctors who have patients in the institution prescribe the length of time for the various patients to work as well as the kind of work, such as light, active, etc. Weaving, reed and raffia basketry, clay modeling, simple wood-work, painting, hooked and braided rug making and general repairing, are some of the types of work being accomplished by the patients of the institution. In most cases the materials are purchased by the patients and are sent home, while other articles are placed on general sale. In summer, a great deal of the work is done on the lawn under shade trees, while in the winter patients work on the large sun-porches.

Those in charge of the occupational therapy work are able to study the relationship of the work to the mental condition of the patients. When the doctors make their visits the work is examined, and a full report obtained with all the observations that have been made. Graphs are also kept of the amount of time spent by each patient each day with notes as to the progress of the patient. The relations between the instructor and the patient are very individual and close, because of the nature of the institution.

OCCUPATIONAL THERAPY ACTIVITIES IN KENTUCKY

Interest in occupational therapy is widespread in Kentucky, as is evidenced by the activities of various institutions.

Central, Eastern and Western State Hospitals for the Insane have had good occupational therapy departments for a number of years.

Mrs. Daffen, of the St. Louis school, is doing notable work at Waverly Hill Sanatorium for tuberculosis, Waverly Hills.

Dawson Springs United States Veteran's Hospital now has a department of occupational therapy.

Volunteer work has been done in the Children's Free Hospital, Louisville, for two years. For many years the Blind Institution, Louisville, has maintained a workshop which, although it is not strictly occupational therapy, has reclaimed many, and kept all the school happy.

The University of Louisville has equipped and maintained an occupational therapy workshop at the Louisville City Hospital since October, 1922.

The newest development in the state is the occupational therapy department of the school of social work, which was organized September, 1923. Splendid co-operation of various institutions has made possible this full training course for aides. The University of Louisville, the Louisville Normal School, the City Hospital Workshop and several medical specialists all contributing instruction have aided the school of social work, which is an exponent of the welfare league (community chest) of the city, and which is affiliated with the University of Louisville, to give a full time course in occupational therapy. The school of social work has been able to secure several prominent craft workers to assist Miss Mary Louise Speed who, in addition to directing the course, does part time teaching. The medical lectures are all given by doctors who have felt the need of occupational therapy in the hospitals in the city and for their private patients, and are therefore willing to contribute their time to this teaching. The University of Louisville and the Louisville Normal School furnish the design, anatomy, physiology and psychology and primary kindergarten, as well as the workshop and the direction of the course. Practice work will be done in various hospitals near and in Louisville. The course covers six hours of work daily for one and one-half years. The University of Louisville grants a certificate for the work.

Another splendid piece of work is being done by the Junior League, Louisville. It has secured floor space and a show case in one of the largest department stores of the city and there sells articles made by patients taking occupational therapy. This organization is working toward having an occupational therapy shop of its own. On December 7, the Junior League will give a Mah Jong ball at the Brown Hotel for the benefit of the prospective shop.

A Kentucky Occupational Therapy Association has also been organized.

City Home for Aged and Infirm, the King's Daughters' Home for Incurables, two private sanatoriums, the children's hospitals, and the Detention Home have all shown their interest in occupational therapy and only lack of funds has kept them from installing departments.

BOSTON SCHOOL REPRESENTED ON STATE HEALTH COMMITTEE

The Boston School of Occupational Therapy is represented this year on the general Massachusetts State Federation of Public Health committee and it is thought that through this medium it will be able to make real progress in bringing to the attention of the Massachusetts club women the actual work being done in the occupational therapy field.

The school entertained the chairmen of the public health committee of the state federation of women's clubs at an informal tea on November 12, 1923. Mrs. Walter McNab Miller was the guest of honor. Mrs. Miller gave a short talk upon the progress which is being manifested throughout the country in the promotion of health work. She expressed her personal interest and belief in occupational therapy.

AMBITION

"You will never get anywhere unless you have higher ideals than this," preached the woman to whose door the tramp had applied for assistance.

"Are you really content to spend your life walking around the country begging?"

"No, lady," answered Weary Willie. "Many's the time I wished I've owned a Ford."

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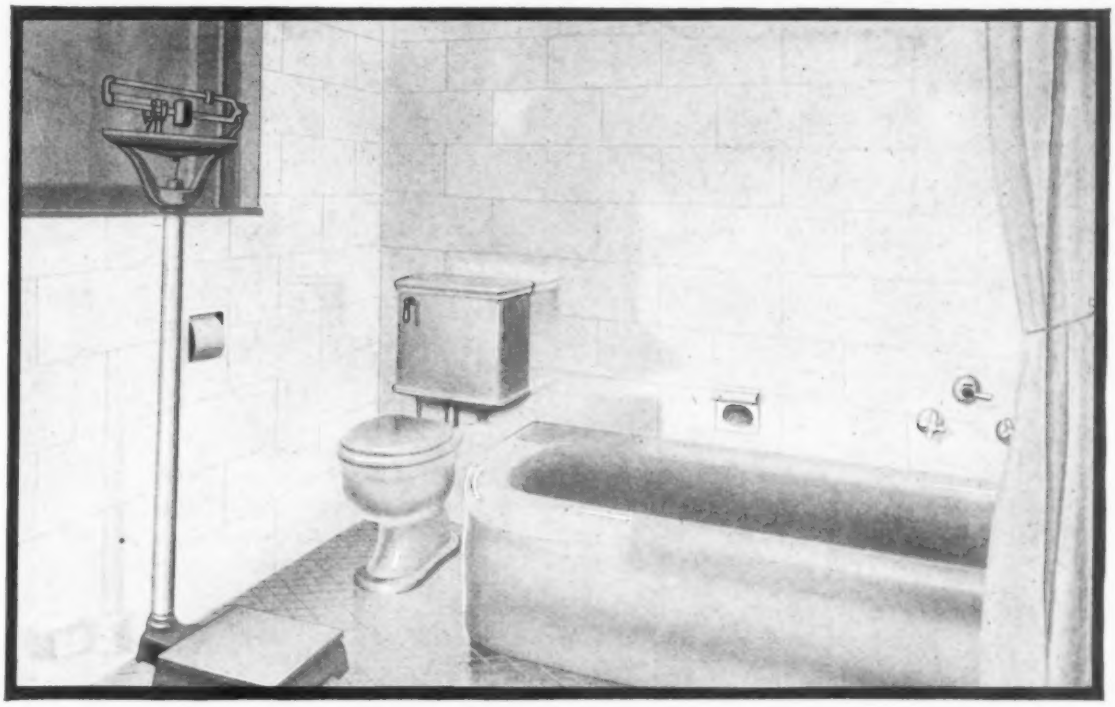

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LETTERS TO THE EDITOR

AN INVESTIGATION OF SURGICAL GAUZE PACKING

To the Editor:—

Believing that the following study, in connection with surgical gauze packing, might be of interest to the whole hospital field, I am sending you this report of results obtained.

Complaints about the gauze used for surgical packing prompted this investigation. The specific complaint in each instance was that the packing gauze was tender, and on being removed from the wound, several days after operation, would tear leaving part behind.

Investigation showed the following facts: (1) The gauze used is a regular twenty-four by twenty dressing gauze. In making up the packings in the dressing room, the gauze was so cut that the pull was exerted in the weaker, twenty thread, instead of the stronger, twenty-four thread, direction.

Tests were made of the tensile strength of this gauze, cut in one of the standard packing sizes; namely, four and a half inches by twenty-seven inches, and, to show the comparative effect of repeated sterilizations, tests were also made on samples that were sterilized ten, twenty, thirty, forty, and fifty times. The average results measured in pounds of pull necessary to tear a four and one-half inch piece of gauze, cut in the twenty-four and twenty thread directions, respectively, were as follows:

Sterilization	24 threads	20 threads
0	64*	26
10	54*	23
20	37	15
30	38	13
40	20	10
50	16	8

*Not torn.

(3) The effect of pus, bile and other wound discharges upon packings was not tested on account of the obvious difficulties.

The following conclusions were reached:

(1) The tensile strength of four and one-half inch gauze, cut in the twenty-four thread direction and sterilized up to ten times, was so great that a pull of fifty-four pounds failed to break it. It is unlikely that any gauze is re-sterilized so many times before use. Gauze sterilized many times begins to take on a brownish tinge and would be quickly noticed by the surgeons.

(2) Repeated sterilization does weaken the gauze in direct proportion.

(3) The tensile strength of gauze is from two to three times as great in the twenty-four as in the twenty thread direction.

It is recommended that in order to rule out any possible weakness in the gauze itself, all gauze for packing be cut in the twenty-four thread direction, and that dressings showing the brownish discoloration from repeated sterilization be discarded or used for other purposes.

JOSEPH TURNER, M.D.,
Assistant Director, Mount Sinai Hospital, New York, N. Y.

ARCHITECT PLEASED WITH BOOK OF PRIZE PLANS

To the Editor:—

We have just received your new book of "Architectural Plans for a Small Hospital" for which we thank you cordially. The book is so helpful and so attractive in appearance that we believe it is of great value to architects and should be much in demand.

OLOF Z. CERVIN,
Cervin and Horn, Architects, Rock Island, Ill.

PUBLICITY ARTICLE IN WIDE DEMAND

To the Editor:—

Kindly let me know whether you can spare a couple of hundred reprints of Mr. Keeler's article, "Publicity Through Service" which appears in the December 1923 issue of THE MODERN HOSPITAL.

I would like to hand a copy of this article to every doctor, intern, nurse and employee of this hospital.

GEORGE E. HALPERN,
Superintendent, The Lebanon Hospital, New York, N. Y.

To the Editor:—

I am anxious to obtain several hundred reprints of Mr. Keeler's article, "Publicity Through Service" which appeared in the December issue of THE MODERN HOSPITAL for distribution among the employees of the Henry Ford Hospital.

This is the best article on courtesy applied to hospital employees that I have ever read, and I believe that the distribution of reprints of the articles among our employees will be most effective.

W. L. GRAHAM,
The Henry Ford Hospital, Detroit, Mich.

UNPAID BILLS AND HOSPITAL LEGISLATION

To the Editor:—

You have shown such willingness to give audience to my views on hospital service from time to time that I shall chance further expression of them relative to your editorial in the March, 1923 number "Do Unpaid Bills Call for Legislation?"

I agree with the editor in his adverse criticism of the suggestion that delinquent hospital patients should be made criminally liable as the laws provide in the case of hotel patrons who "jump" their board bills. It seems to me that we might well spend a little more time on

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diagnosis of the hospital patient's condition before trying any radical treatment—legislative or otherwise. After reviewing legislation in various fields of public service for many years, I am convinced that legislation is almost always better as a last resort than as a first resort for the solution of most social problems.

The whole question of hospital service and payment for it, needs airing. And to that end I want to raise a few questions which seem pertinent to me in the hope that you may find it worth while to pass them on to others of your readers more experienced and better informed. I should like to see a thorough discussion of these questions in the pages of THE MODERN HOSPITAL.

As I have had opportunity to observe hospital development in this country, both in large and small communities, it has appeared to me that hospital service is being promoted on a scale of magnificence far beyond public need or public ability to support. Is it true or not that the present tendency in hospital construction and equipment is toward extravagance? Is it true or not that the public is being miseducated to demand a type of hospital service that it cannot afford? Is it possible for private hospitals to be built and equipped so that the patient can have efficient care at a price he can afford to pay? I believe there is a decided trend toward luxury in hospital construction and appointment that is not primarily the result of public demand and not essential to public welfare.

Many hospital superintendents have told me that there is greater demand for expensive rooms than for inexpensive ones, and no doubt this is true, but the reason for it is, I believe, not solely the patient's desire to satisfy his own ego. It is due, in my opinion, to over-stimulation by hospital authorities, physicans and surgeons and the press of the nation that hospital elegance means hospital efficiency. The bigger, more imposing, more magnificent the hospital, the more it is boosted by everyone concerned. The patient naturally comes to consider that good service is not to be had except in a hospital of such type. It is true that such hospitals attract the most prominent physicians and surgeons, for connection with them carries a certain prestige. It may be the fact, therefore, that the patient is guaranteed better service in a hospital of this type. But, after all, isn't the trend wrong; isn't the dominant motive in much of the present hospital development one of enhancing group prestige rather than of providing efficient and economical public service?

You can readily imagine what it means to the average "white collar" salaried man to have to pay for several weeks' care in an expensive private hospital at $50 or $60 a week plus the inevitable and numerous extra charges for x-ray, laboratory, anesthesia, special nursing, etc. To pay his bills promptly when he is discharged is often impossible and to pay them at all may mean an unwarranted sacrifice of hard earned savings. I am for anything in the way of refinements of hospital service that will make the patient's sickness easier to bear. But we are going about it in the wrong way. We are encouraging him to demand luxuries that he doesn't need and can't afford. When a man goes to a hotel he seeks one that suits his needs and purse. If his needs are a good clean room, a comfortable bed and satisfying meals, he goes where he can get them at a price he can pay because he knows that when he leaves he must pay his "shot." But the hospital patient is encouraged to go to an expensive hospital, or at least is not discouraged from going to an expensive one, and he knows that when he is discharged he can defer payment, if the charges exceed his funds on hand. A charge account is invariably an inducement to extravagance or spending beyond one's means.

I believe THE MODERN HOSPITAL would render a distinct public service by an effort to counteract this overstimulation of the public demand for a type of hospital service it isn't able to support. Can't we get back to greater simplicity of hospital construction and equipment without impairment of service? Isn't it possible to put efficient, modern hospital service within the reach of the average patient so that he can pay his bills promptly and without putting such tremendous burden on his resources? If those who are interested in the promotion of hospital work would encourage patients to live within their means, even in hospitals, wouldn't it help to reduce the number of delinquent patients? Many patients if properly advised would accept common ward service, or two or three bed ward service instead of individual private rooms. If they don't need individual private rooms and can't well afford them, ought they not to be discouraged from demanding them? Exclusiveness in a hospital isn't always an added benefit to the patient and sometimes it is no benefit at all.

Another thought on the matter of hospital bills. It is not at all uncommon to find hospitals overcharging their patients by charging for a full day's care on the days of admission and discharge, although the patient may have been admitted in the evening and discharged in the morning. Imagine what a protest would be made by a hotel guest who was charged in this way. Where the situation in a hospital, as regards payment for board and room, is the same as that in the old "American Plan" hotel, wouldn't it be practical to calculate charges on the same basis? In the "American Plan" hotel the day is divided into quarters—breakfast, one quarter; luncheon, one quarter; dinner, one quarter; lodgings, one quarter. If a guest arrives before breakfast and leaves before breakfast the following day, he is charged for one day—not for two days as is often the case in hospitals. The hospital patient who has been charged for two days' service when he actually had less service, has a right to feel dissatisfied, and every doctor knows that a disgruntled patient is a slow payer. (I might say that I have tried out this "American Plan" in a pay convalescent home and it works splendidly.) Wouldn't the mere matter of presenting honest bills help the hospital to collect them more promptly? It might be necessary for the hospital to raise its per diem rates slightly, but frankly and openly. That would certainly be better than over-charging the patient and sending him away with the feeling that he has been unfairly treated. Perhaps this idea is not new and it may be that others will see certain proper objections to it, but I have never seen any discussion of such a proposal.

In your editorial you mention the desirability of letting the patient know what his hospital care is to cost, so that he won't be shocked when he gets his bill. This is right of course, but responsibility should not be wholly on the doctor who sends him to the hospital, as you imply. When the patient is admitted to the hospital he should be informed about the hospital charges as a matter of routine. Perhaps hospitals might well take another leaf out of the hotel book on this matter. Most good hotels post in each guest room a card giving full information of the service available to the guest and its cost. Wouldn't it be practicable for the hospital authorities to furnish each patient admitted with a similar card showing what his room rate is, what special charges are made for x-ray, laboratory, use of operating room, anesthetic, special nursing, etc., the reasons for such charges and the reasons why the hospital asks prompt payment? If the pa-

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tient finds as time goes on that his resources are becoming exhausted, wouldn't it be wise to advise him to consult the hospital authorities and make some arrangement for reducing the cost or for paying it in re[illegible] installments? The time to do this is when the patient is under supervision before the day of his discharge. Under present conditions the patient who does not find on his discharge that his bill is larger than he thought it was going to be is an exception—and the patient who finds it so is going to be a slower payer than the one who finds it exactly as he has calculated.

To sum up, my suggestions for improving hospital bill collecting are:

1—Educate the public to demand only efficient hospital service and provide that minus luxuries that the public can't well pay for, 2—Charge patients honestly for the actual time spent in the hospital—that is, on the basis of a hospital service day instead of a calendar day, 3—Inform patients thoroughly of all charges, the reason for such charges and the necessity for prompt payment. Adjust service charges to the patient's means as and when indicated and *before* his discharge.

CARL E. MCCOMBS, M.D.,
National Institute of Public Administration.

To the Editor:—

It is my opinion that hospital administrators are taking an improper stand as to the cause of unpaid bills. I believe that legislation may be indicated as a protection against dead beats, but I am firmly convinced that the dead beat is but a very small cause of unpaid hospital accounts. The trouble is at the source, a failure on the part of hospitals to make a financial diagnosis of their patients, and an insistence on the part of patients to obligate themselves for facilities beyond their ability to pay.

I agree with Dr. McCombs that this question is one of the most vital ones in the health field today. The cost of hospital operation is going up by leaps and bounds, until there will come a point very soon, I am fearful, beyond the ability of the average individual to pay. As offsetting this, the ratio of contributed dollars to earned dollars is becoming alarmingly high, and there will, by very nature of things, come a point beyond which it will be impossible to expect the community to bear the burden in the way of donated funds.

I cannot agree with Dr. McCombs, however, that "magnificence of construction and operation" are the causes of this increased cost. As a basis of discussion, I am submitting the cost of Mount Sinai Hospital, which is $6.57 per day during the year 1922, and give you also the percentage of this per capita cost chargeable to various major divisions of expense.

Administration	9.7%
Housekeeping	8.2%
Laundry	3.3%
Heat, light, power and maintenance	12.9%
Dietary	28.2%
Nursing	20.7%
Professional supplies and salaries	8.6%
X-Ray	3.8%
Laboratory	2.4%
Anesthesia	1.0%

It must be borne in mind that magnificence of construction does not reflect in the per capita cost only insofar as that elaborateness causes undue maintenance cost. To illustrate this point specifically, one might say that marble corridors would be magnificence of construction, but as a matter of fact marble corridors would reduce operating cost, and inasmuch as most of our hospitals are built from contributed funds, and items of interest on investment and depreciation rightfully are not included in the operating cost, I can see no particular criticism of this magnificence of construction that Dr. McCombs speaks of. I know of only three or four institutions in the country that have that magnificence of construction beyond the actual necessity for a good hospital building.

What then are the causes of undue rise in hospital operating costs? In my opinion, this should be divided into five major causes, i. e.

1. Placing of the institutions' accounting system on a sounder basis; the inclusion of all operating expense in the per capita cost total and the consequent realization on the part of boards of trustees of hospitals of what their actual operating cost is, and the automatic increase in the rates charged.

2. The increase in the professional demands of the institution. I mean by this that with the more general acceptance of the premise that the hospital must be the health center of the community it serves, there is the necessity of providing every known means for the scientific diagnosis and treatment of disease. This in itself materially increases the per capita cost as will be reflected in the foregoing table.

3. A higher ratio of personnel to patients due, first of all, to increased demand spoken of under division two, and due also, as I see it, to a lesser number of volunteers in hospital work. This lower number of volunteers is, in my opinion, due first of all to the lesser availability of volunteers and a further realization on the part of hospitals that volunteer assistants cannot bring that trained mind to the work, that is so necessary to hospital operation of today.

4. The gradual but universal increase in the compensation of the personnel of institutions comparable with compensation paid individuals of equal responsibility in other walks of life.

5. A material increase in the cost of all commodities used in hospital operation.

I should like to discuss several points in Dr. McCombs' letter.

A. The fourth paragraph of this letter states the belief that there is a definite trend towards luxury in hospital construction and appointment. If this statement has in mind the comparison of the hospital of today with the hospital of ten years ago, and does not take into consideration definite change in the status of the hospital as a functioning unit of the health program of the community, then there is no question that there is a greater elaborateness, but I would hardly say that it is a luxury. Certainly the inclusion in the hospital service of all the refinements of medical practice is a thing that is to be stimulated rather than retarded, and with few isolated exceptions it is a hospital of these refinements that has the high per capita cost.

The point that the doctor makes that there is an overstimulation on the part of hospital authorities and infinitum, of the thought that hospital elegance means hospital efficiency. I don't think the point is quite fair. Competent laboratory facilities spread over a small patient day occupancy will absorb a relatively higher ratio of total cost of operation than it will if spread over a high patient day occupancy and, after all it is the opportunity of carrying these eleborate facilities of therapy and diagnosis that causes hospitals to develop into large units.

B. The comparison of a hospital to a hotel is not quite just. About seventy-five per cent of the clientele of a hotel are individuals traveling on expense accounts. The

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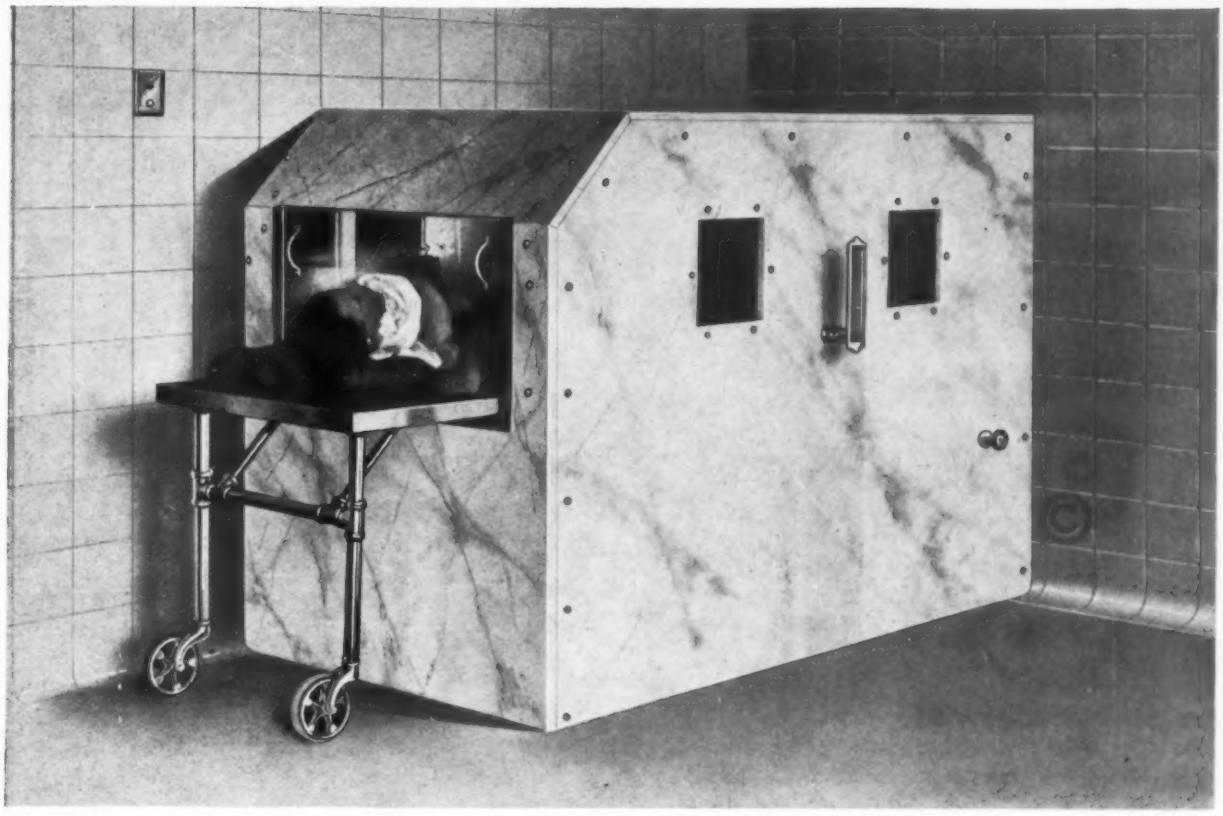

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Inside it is provided with perforated brass steam coil, steam control valve, and special type thermometer. The cot is special zinc covered, in nickel-plated frame, with extended rubber-tired swivel wheels and brass channels on under side of top; it is supported on roller bearings mounted in top of special galvanized angle iron frame on inside of cabinet. Interior is lighted by one 75-watt-weather-proof lamp and has combination floor drain and trap.

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other twenty-five per cent are folks who are traveling occasionally on business or who are on vacations. The later group, if they have an income that requires husbanding, have saved up for this vacation. They go to a hotel because they want to. They go to a hospital because they have to. Certainly I don't believe that the prevailing rates at the most expensive hospitals can compare at all with the rates at hotels in the same community for a comparable service rendered.

Dr. McCombs makes the point that a patient could be inveigled into going into semi-private or open ward accommodations. May I call attention to the fact that his plan may offer a solution so far as the individual patient is concerned, but it does not offer a solution for the financial situation of a hospital. If all patients were to go into semi-private accommodations—which in almost every instance are part-pay accommodations—where is the hospital to be subsidized for the difference between the actual cost of operating these beds, and the income that is received from them? It is my definite belief that the thought that private room accommodations cost more than semi-private or ward accommodations in every operation has been definitely exploded.

There is no question that the subject is a critical one. To my mind, the only solution is a more absolute proportioning of pay, part-pay and free beds of a hospital.

With a fair estimate of the expectancy from the community of donated income, and the further acceptance of the fundamental principle that private rooms should pay the cost of operation plus a reasonable degree of profit, there is easily computed an average gross potential income for the hospital and with this figure it is comparatively easy to allocate bed facilities producing this income.

Sometime some one is going to evolve a financial scheme for our health program that is going to be sounder than the present one, and when he does the world will rise up and call him blessed.

F. E. CHAPMAN,
Director, Mt. Sinai Hospital, Cleveland, O.

To the Editor:—

I feel that Dr. McCombs has opened a subject that at some time or another has caused all hospital administrators more than ordinary concern and, although his remarks seem to be aimed at private patients, they are not by any means the worst offenders on the question of unpaid accounts.

We have in Canada several modern and well equipped private pavilions and a general inquiry elicits the fact that the moderately priced rooms are in greater demand, even by those whose social status in the community would lead one to believe that the reverse should be the case. There is no doubt that the habit of luxurious living and senseless spending incurred during the War by many is still with us, and every effort should be made whereby sensible and economical living should become the order of the day rather than a continuation of extravagance.

It is quite true that the public is being educated to demand a type of service that was unheard of fifteen years ago, but I do not think we have erred in this respect. The advances that have been made in methods of diagnosis and treatment in that time have probably never been equalled in a like period of time in the world's history. I refer in particular to departments such as x-ray, pathology, metabolism, physio-therapy, dietetics, and others. True, they are expensive, but I feel that as an eye-witness they have been effective.

We have not kept these modern methods solely for the private patient but rather have we by popular literature allowed the general public to see behind the scenes and by seeing to demand the latest and best treatment.

It is almost inconceivable to realize that there are hospitals that still charge by the calendar day instead of the hospital service day. It would be interesting to know what explanations are given to the patients that object to this practice.

Dr. McCombs' third suggestion is one that, in practice, has done a great deal to minimize "bad accounts."

In the Montreal General Hospital we have had for two years a graduate nurse in the general office who acts as the intermediary between the office and the patient. It is her duty to see that the form of guarantee has been signed by the patient, whether public or private, and also to receive from the patient a signature that he has received and understands the printed sheet that explains at length his charges and reasons for same. It seems inevitable that extra charges should be made, for it does not seem fair that the patient who comes in with an uncomplicated and straightforward medical condition should be made to bear a portion of the cost of the patient who must be diagnosed from several angles, and many of them expensive ones.

It is also her duty to inquire into the reasons for accounts being overdue. In the case of private patients who are unknown to the hospital, a given time is permitted and the patient is then moved into a public ward. I might say in fairness to our system that this only occurred once in the last year, but the existence of this rule has undoubtedly been responsible for prompt payments in certain cases.

In the case of public ward patients one finds more frequently deliberate attempts at fraud. Especially is this true in the hospital where patients are paying different rates in the same ward. They do not take into consideration the fact that many angles must be considered before the given rate is arrived at, for example, single or married patients with or without dependents, lack of employment, prolonged illness at home before coming to the hospital, a longer stay in the hospital than was thought necessary at first, a knowledge of the standards of living. It is not uncommon for a patient to pay $2.50 a day for a week or two, and at the end of his stay to be paying $1.50 a day or less.

It is necessary, without a doubt, that the patient should have a full knowledge of what he should pay and what he should pay for, but it is equally necessary that the hospital should keep itself informed as to why those payments are not being met, and many a bad account should be marked cancelled on the patient's discharge instead of being carried on the hospital books as an open account to be paid.

I feel that the hospital that has to depend to a large extent on public benevolence, will present a much stronger case if, after every due precaution and deliberation has been made on each individual case, the strongest measures possible are taken to prevent deliberate fraud, and I would not hesitate to bring before the courts an individual or corporation who was shown, after every consideration had been given, to be deliberately beating a semi-charitable institution out of its account; but this should be, naturally, as a last resort and only taken after careful consideration by the governing body of trustees or management.

A. K. HAYWOOD, M.D.,
Superintendent, Montreal General Hospital, Montreal, Can.

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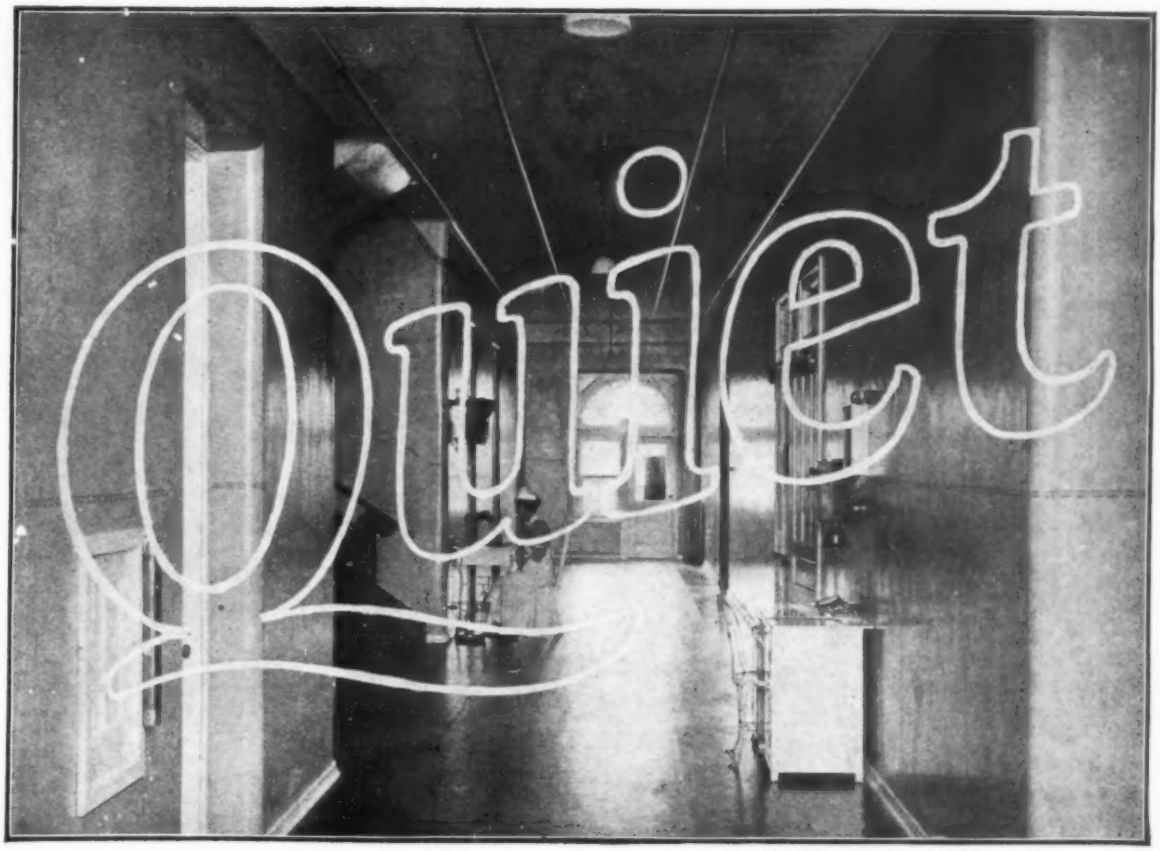

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BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

HEALTH TRAINING IN SCHOOLS

By THERESA DANSDILL. National Tuberculosis Association, 370 Seventh Avenue, New York.[1]

Time was, and not so very long ago at that, when disease was considered an act of Providence to be borne with resignation and not to be avoided by any human effort. The result may be observed in any little country cemetery dating from early Colonial days, where a row of little headstones mark the passage of large families of children, eight or ten often dying under the age of five. Along side of these little graves may often be found those of a mother or two worn out by child-bearing and hard labor.

But times have changed and we realize that it is better to have fewer children and raise them in health rather than to raise many and have them die before maturity. The old process of allowing Dame Nature to take her course is now realized to be wasteful in the extreme, and the direct application of modern sanitary knowledge has resulted in an extraordinary fall in the infant death rate which is generally recognized as one of the most astonishing testimonials to the value of scientific application of our knowledge of the nature of disease, which the present century has witnessed.

The country school of the middle of the last century was satisfied if it taught a little reading, writing and arithmetic. The word hygiene was never heard and any information for the intelligent direction of the pupils lives was never heard. To-day schools throughout the United States are teaching children hygiene, fully recognizing that the parents are mentally ossified and that only by educating the children are any advances to be made. But, even a couple of decades ago the teaching of hygiene consisted largely of memorizing certain names and descriptions of physiological and anatomical facts with a course of "shockers" concerning the baneful effect of alcohol and tobacco intended to frighten the children rather than to inform them, and consisted largely of extremely inaccurate and lurid information. Such cramming had practically no effect upon the lives of those who had to submit to it.

Within ten years the whole situation has changed. Improved pedagogic methods have replaced the old memory system and teachers have been trained to interest children in games illustrating the application of simple hygienic methods, to understand that cleanliness, good food, and ample sleep are just as important as the mental side of their education. It is astonishing to see how much children are interested in these new facts and how earnestly they discuss questions which their teachers bring up in class, but also, sad to say, how little sympathy they receive from their parents of the older generation.

This admirable and interesting book should certainly be a source of inspiration to teachers, nurses, and all other educational health workers who want to make the formation of good habits of health interesting. While the text is largely a compilation from writings of authorities on hygiene it is interspersed with questions and directions which should be stimulating to the pupils themselves. The quotations give sound advice not of the sensational variety. Much use is made of illustrations and examples from the writings of such great public characters as Roosevelt, Trudeau, Gorgas and Florence Nightingale. Ample bibliographic references and collateral reading which the teacher may wish to do are included. It is impossible to imagine a better text-book for the subject.—F. C. W.

LAUNDERING: HOME—INSTITUTION

By LYDIA RAY BALDERSTON, A.M., Instructor in Housewifery and Laundering, Teachers College, Columbia University, New York, N. Y.[2]

Laundering is becoming such an important problem in the home as well as in institutions that housewives and institutional directors have for some time been asking for help in the management of this vital phase of the household. In answering to the call for help, Lydia Ray Balderston has published "Laundering: Home-Institution" designed primarily to give definite help concerning the proper methods of performing the actual processes involved in cleaning a garment. The discussion includes a detailed account of the effect on laundering processes of fiber, fabric, and color, the best way to conserve these and to secure the desired finish.

The matter of laundering supplies, how to buy and use them, is treated with a view toward their use in washing processes rather than their chemical reactions. The selection, cost and care of equipment is studied in detail in one section of the book. Unwise buying of equipment should be prevented by a study of this section of the book.

For the director of an institution, helpful material is offered on the administrative problems of laundry buildings and equipment and of handling large quantities of linen as well as a guide for the manual operation of large scale laundry work.

The book is also designed for teachers in practical arts in their domestic and institution laundry courses as well as a reference book in the courses on household and institution management. The manual of laundry procedure is not only a comprehensive scientific study which has come as the result of years of research in this work, but is an attractive book made interesting through its 188 illustrations, and one which the casual reader will enjoy.

1. National Tuberculosis Association, New York, 1923.

2. J. B. Lippincott Company, Philadelphia, Pa., 1923.

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NUTRITION OF MOTHER AND CHILD

By C. ULYSSES MOORE, M. D. M. Sc., (Ped.) Instructor in Diseases of Children, University of Oregon Medical School, Eugene, Ore. Including Menus and Recipes By MYRTLE JOSEPHINE FERGUSON, B. S., B. S., in Home Economics, Professor of Nutrition, Iowa State College, Ames, Iowa.[1]

Dr. Moore has written this book primarily for mothers, and it should prove of value to them, especially to young mothers. The facts and theories of nutrition which are generally accepted today are given in a very readable manner with specific application to the feeding of children.

The chapter on rickets, and the one on diet during pregnancy and lactation tell in a forceful way the cause and prevention of conditions, all too frequently found in infants, which may be prevented by proper diet and care. If every mother would follow the suggestions in these chapters, there would be a noticeable improvement in the general sturdiness of many children, and a noticeable decrease in doctors' bills. It would be a blessing if every child could have the benefit of what Dr. Moore says about teeth.

A strong point is made of the importance of vitamins and minerals in the diet and the newer idea in breast feeding is emphasized. Not all pediatricians will agree with some of the more emphatic of these statements but, on the whole, the book is a sensible discussion of the subject, written in a way that may easily be followed by the non-professional.

There are also several pages of menus and recipes by Miss Myrtle Ferguson which gives a variety of ways of serving wholesome food. The recipes are simple, requiring little work in preparation, but of an appetizing form. Social workers and nurses will be grateful for this helpful book.—L. C. G.

PHYSIOTHERAPY TECHNIC

By C. M. SIMPSON, M.D., Formerly of the physiotherapy service, U. S. Army, St. Louis, Mo.[2]

Dr. Sampson has had a tremendous amount of experience in the use of physiotherapy in relation to various kinds of medical and surgical illnesses. In no branch of physical treatment is the technique so important as in physiotherapy, particularly the electrical treatment. All who read the book will feel that Dr. Sampson has carefully studied the effects of the different procedures which he outlines and, although many will not agree in the particular technique, finding other methods more satisfactory, it is a valuable book for anyone who is interested in this form of treatment.

The war has opened the way for a better study of these natural powers to be used for man's benefit. This is well shown by Dr. Sampson, who has spared no pains in the preparation of this extremely technical treatise on physiotherapy. It should be read by all those whose practice is chiefly along this line.—L. T. S.

THE MEDICAL DEPARTMENT OF THE U. S. ARMY IN THE WORLD WAR

VOL. V: MILITARY HOSPITALS IN THE UNITED STATES,

By LIEUT.-COL. FRANK W. WEED, M.C.; prepared under the direction of Major General M. W. Ireland, M.D., Surgeon General of the Army.[3]

A complete and interesting record of the military hospitals of the United States during the World War is open to the public in "The Medical Department of the United States Army, Vol. V: Military Hospitals in the United States" which has recently been compiled by Lieut.-Col. Frank W. Weed under the direction of Major General Merritt W. Ireland. The volume aims to furnish a record of experiences incident not only to the actual provision of the military hospitals but to their administrative operations as well. It also records the histories of the hospitals separately, in so far as possible. As it was impossible to include complete histories of all the military hospitals of the country a representative of each of the various types was selected for description.

The accomplishments and staff requirements of each hospital are graphically given in statistical tables which exhibit numerically the number of patients treated and the personnel provided for their treatment.

The volume contains over 200 illustrations which makes it interesting as well as a very informative handbook for those interested in military hospitals.

1. Lippincott's Nursing Manuals, J. B. Lippincott Company, Philadelphia, Pa., 1923.
2. C. V. Mosby Company, St. Louis, Mo.
3. Government Printing Office, Washington, D. C.

BOOKS RECEIVED

THE ELEMENTS OF SCIENTIFIC PSYCHOLOGY. By Knight Dunlap, Professor of Experimental Psychology," "Personal Beauty and Racial Betterment," etc. Illustrated. C. V. Mosby Company, St. Louis, 1922. Author of "Mysticism, Freudianism and Scientific Psychology in the Johns Hopkins University, Baltimore;

APPLIED PSYCHOLOGY FOR NURSES. By Donald A. Laird, assistant professor of psychology, University of Wyoming. J. B. Lippincott Company, Philadelphia and Londin, 1923.

FOOD FOR THE DIABETIC. What to eat and how to calculate it with common household measures. By Mary Pascoe Huddleson, consulting dietitian, with an introduction by Nellis Barnes Foster, M. D., Cornell University. The MacMillan Company, New York.

HEALTH BUILDING AND LIFE EXTENSION. A discussion of the means by which the health span, the work span and the life span of man can be extended. By Eugene Lymon Fisk, M.D., medical director, Life Extension Institute, New York. The MacMillan Company, N. Y., 1923.

THE MEDICAL DEPARTMENT OF THE UNITED STATES ARMY IN THE WORLD WAR. Volume V: Military Hospitals in the United States, prepared under the direction of Major General M. W. Ireland, M.D., surgeon general of the army, by Lieut. Col. Frank W. Weed, M.C., U. S. Army, Washington, D. C. Government Printing Office, 1923.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners, by leading members of the medical profession throughout the world, edited by Henry W. Cattell, A.M., M.D., Philadelphia, with the collaboration of Charles H. Mayo, M.D., Rochester, Sir John Rose Bradford, M.D., London, William S. Thayer, M.D., Baltimore, Md., Frank Billings, M.D., Chicago, A. McPhedran, M.D., Toronto, Sir Humphrey Rolleston, K.C.B., M.D., D.C.L., London, Seale Harris, M.D., Birmingham, Ala., Hugh S. Cumming, M.D., D.P.H., Washington, D. C., John G. Clark, M.D., Philadelphia, James J. Walsh, M.D., New York, Charles Greene Cumston, M.D., Geneva, John Foote, M.D., Washington, D. C., Charles D. Lockwood, M.D., Pasadena, Cal. Correspondents, A. H. Gordon, M.D., Montreal, and James Burnet, M.D., Edinburgh. Volumes 2 and 3, thirty-third Series, 1923. J. B. Lippincott Company, Philadelphia, 1923.

ANNUAL REPORT OF THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1923. Government Printing Office, Washington, D. C., 1923.

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Government Hospitals Authorized.—According to the instructions of the Secretary of War, the following government reserve hospitals have been organized: Surgical Hospital No. 40 (Waterbury Hospital Unit), Waterbury, Conn.; Evacuation Hospital No. 47 (Grant Hospital Unit), Columbus, Ohio; General Hospital No. 77 (Jewish Hospital Unit), Brooklyn, N. Y.; General Hospital No. 76 (Lebanon Hospital Unit), New York, N. Y.; and General Hospital No. 99 (Ohio State University College of Medicine Unit), Columbus, Ohio.

Methodist Hospitals Expand.—The Methodist Episcopal Church announces that more than $16,000,000 has been added to the properties and endowment of the hospitals, children's and old people's homes of the church since 1920. During the last year the total value of buildings nearing completion was $2,445,000 and the value of buildings dedicated, $3,450,000. Nearly $2,500,000 was raised in special campaigns during the last year. At present the church has eighty-one hospitals, forty-four homes for children, thirty-nine homes for the aged and eleven other institutions of a total valuation, with endowment, of $40,000,000. During the past year 4,000 orphans and half-orphans were cared for and 1,800 men and women.

Colorado

Dedicate Second Unit of Hospital.—The second unit of the Beth Israel Hospital, Denver, was formally dedicated recently. Unlike the Home for Aged Jewish People, the hospital is non-sectarian. Every room in the institution has been endowed as a memorial. Dr. Haskell Cohen will head the medical staff.

District of Columbia

Propose Nurses' Home.—Legislation providing for a modern home for nurses as a new wing for Columbia Hospital for Women, Washington, D. C., has been introduced into Congress. Plans have been submitted by David Lynn, architect of the Capitol.

Florida

Hospital Sold.—The Marvin-Smith Hospital, Jacksonville, has been purchased for $65,000 by the Jacksonville Hospital Association of which Dr. H. H. Humphreys is president.

Georgia

Archbold Memorial Hospital.—A hospital to be known as the John D. Archbold Memorial Hospital is being erected at Thomasville by J. F. Archbold in honor of his father. Colonel James L. Bevans, Washington, D. C., who recently retired from the medical corps of the army, has been appointed superintendent. Colonel Bevans will continue to reside in Washington until the hospital is completed, probably late next fall.

Illinois

Buys House for Nurses' Home.—The John B. Murphy Memorial Hospital, Chicago, has bought a residence near the hospital to be used for a nurses' home.

Bacteriologist Appointed.—Miss Daphne Conover has been appointed head bacteriologist and laboratory technician at Ingalls Memorial Hospital, Harvey, which opened November 1.

Fire Invades Chicago State Hospital.—Nineteen persons were burned to death in the ruins of Chicago State Hospital, Dunning, which burned December 26. The tuberculosis pavilion was completely destroyed.

Purchase Globe Hospital.—The Globe Hospital, Freeport, has been purchased by the Deaconess Society of the Evangelical Church of the United States which will take over the institution immediately.

Bequest to Children's Memorial Hospital.—The Children's Memorial Hospital, Chicago, has received a bequest estimated at $400,000 from the late Miss Martha Wilson, formerly president of the hospital's auxiliary board. In her will, Miss Wilson expressed the intention that the fund should be used in the erection of a new building to be used so far as possible for patients who are not now eligible for admission to the hospital.

Plan Hospital Near Marquette Park.—A new hospital is being planned overlooking Marquette Park, Chicago. It is to be a four story building of colonial design to accommodate 140 beds. Each floor will be practically a unit in itself containing doctors' and nurses' rooms, diet kitchen, etc. The hospital will contain x-ray, chemical, pathological, radiographic, and fluoroscopic laboratories. The building will be completed next fall, according to the plans of the architects, Leichenko and Esser, Chicago.

Indiana

New Hospital for Howard County.—A new hospital will be erected for Howard county, Kokomo, soon.

Plan New Lake County Hospital.—Plans are being made for the erection of the New Lake County Hospital, East Chicago.

Psychopathic Ward for City Hospital.—A campaign has been started for the erection of a psychopathic divi-

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sion of the City Hospital, Indianapolis.

Dr. Ross Accepts Superintendency.—Dr. L. F. Ross, Richmond, has accepted the position of superintendent of the Eastern Indiana Hospital for the Insane, Richmond, to succeed Dr. S. E. Smith, who has assumed his duties as provost, Indiana University, Bloomington.

Kentucky

Cumberland Sanatorium Discontinued.—The Cumberland Sanatorium, Somerset, has been discontinued.

Plan Kentucky Memorial Hospital.—A new institution to be known as the Kentucky Memorial Hospital, Whitesburgh, will be erected there soon.

New Building for Evangelical Hospital.—A new building is being planned for the Evangelical Hospital, Louisville. Construction will start in the spring.

Booth Memorial Hospital Enlarges.—A four-story and basement addition will be erected at the Booth Memorial Hospital, Covington. The hospital is owned by the Salvation Army.

Maryland

To Rebuild Sanatorium.—Dr. W. Rushner White, superintendent, Patapsco Manor Sanitarium, Ellicott City, has announced his plans for rebuilding the sanitarium, which was destroyed by fire, recently.

Michigan

New Nurses' Home for Ford Hospital.—Announcement has been made that a new $1,500,000 nurses' home will be erected soon for The Henry Ford Hospital, Detroit. The building will contain the quarters for the school of nursing which is to be undertaken in connection with the hospital in order that it may train its own nurses.

Michigan Association Meets.—The seventh meeting of the Michigan Hospital Association was held at Grand Rapids, January 24 and 25. Some of the subjects which were scheduled to be discussed at the meeting were: the intern service in Michigan hospitals; future activities of the association; diabetes; the practical application of minimum standards in hospitals; psychopathic clinics; the central school of nursing, and hospital liability. An account of the meeting will appear in our March issue.

New Officers for Grace Hospital.—Dr. C. H. Carpenter, recently assistant physician at the Traverse City State Hospital, Traverse City, has been appointed second assistant director, The Grace Hospital, Detroit. Supervisors appointed are: Miss Jeanette M. King, R.N., a graduate of the Auburn City Hospital Training School for Nurses, Auburn, N. Y., supervisor of the maternity department; Mrs. Grace Byers, a graduate of The Grace Hospital Training School for Nurses, supervisor of the pediatric service; Miss Gertrude P. Brydges, a graduate of the University Hospital, Ann Arbor, and recently supervising nurse in the University Hospital, supervisor of the private patients' pavilion.

Minnesota

Hospital for Epileptics.—A hospital for epileptics is planned for Cambridge to be erected at a cost of $40,000.

St. James' Hospital Opens.—The new St. James' Hospital, St. James, was recently dedicated and is now open.

Plan Hospital for Mankato.—The Immanuel Hospital Association is planning the erection of a hospital for Mankato.

Open Children's Hospital.—The Children's Hospital, St. Paul, was formally opened January 1. The hospital will occupy temporary quarters on Smith avenue. It is nonsectarian and will receive children from birth to adolescence. Dr. Walter R. Ramsey is chief of staff.

Nebraska

New County Hospital.—The Douglas county commissioners have let the contract for the erection of a county hospital building at Omaha.

Campbell Hospital Changes Hands.—The possession of the Campbell Hospital, Norfolk, is to pass to the Lutheran Hospital board of North Nebraska, according to a recent announcement.

New Jersey

Enlarge Greenville Hospital.—An addition will be erected to Greenville Hospital, Jersey City.

Plan Convalescent Hospital at South Orange.—Plans have been completed for a $200,000 convalescent hospital at South Orange.

St. Paul's Deaconess Home and Hospital, Pompton Lakes, was dedicated recently.—Dr. William S. Colfax, Clarence L. Vreeland, and David N. Shipee comprise the medical staff.

Holds Series of Clinics.—A series of clinics was recently held in Jersey City Hospital to which all physicians in the vicinity were invited. It is intended to make the hospital a teaching center for physicians and the laity.

Resigns from Brooklyn Training School.—Miss Kate Madden, R.N., has resigned from the Brooklyn Hospital Training School for Nurses, Brooklyn, N. Y., and has accepted the position of superintendent of nurses, Elizabeth Hospital and Dispensary, Elizabeth.

Miss Wittaker Goes to Irvington Hospital.—Miss Mary L. Whittaker has accepted the superintendency of the Irvington General Hospital, Irvington. Miss Wittaker was formerly assistant superintendent of Muhlenburg Hospital, Plainfield, and of the White Plains, N. Y., and superintendent of the Margaret Pillsbury Hospital, Concord, N. H.

New York

Hay Fever and Asthma Clinic.—The Victory Memorial Hospital, Brooklyn, has opened a special hay fever and asthma clinic.

New Director of Tuberculosis Division.—Dr. Jonathan Pearson, Schenectady, has been appointed director of the division of tuberculosis of the state department of health.

Millard Fillmore Hospital.—The board of directors of the Buffalo Homeopathic Hospital announce that the name of that hospital has been changed to the Millard Fillmore Hospital.

Mr. Crane Resigns.—Mr. Charles Crane, superintendent of New Rochelle Hospital, New Rochelle, has resigned his position. Mr. Crane will be engaged temporarily in some consulting work.

United Israel Zion Nurses' Home.—Plans are being drawn for a nurses' home for the United Israel Zion Hospital, New York, a private institution of 175 beds. It is to be a four-story structure 100 by 140 feet.

Infantorium Enlarged.—The Infantorium, located in the Heckscher Foundation, has increased its capacity to fifty beds. Admission is now limited to children under three years of age, having nutritional disorders such as rickets and scurvy.

New Unit for Tuberculosis Patients.—Kings Park State Hospital, Kings Park, having 4,395 beds, is planning a new addition to contain the refrigeration work, dining room and kitchen building for tuberculosis patients. Dr. William C. Garvin is superintendent.

Plan New Samaritan Hospital.—Plans are being made

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for the New Samaritan Hospital, New York, and building will begin in April. The building will be in the form of the letter H and will be built in sections. The first section to be erected will accommodate 100 patients.

Subscribe to Nurses' Home.—The trustees of Mount Sinai Hospital, New York, N. Y., have ratified the building program for the contemplated new nurses' home, Mount Sinai Hospital, and have subscribed $735,000 of the $1,500,000, the amount which the building will cost.

Dr. Emerson to Germany.—Dr. Haven Emerson has gone to Germany to study conditions there. He went at the invitation of the American Friends Service Committee and will visit Breslau, Chemnitz, Dusseldorf, Cologne and parts of the Ruhr region to observe especially the condition of children in hospitals and schools.

Appointed Supervisor of Pediatric Clinic.—The New York Post-graduate Hospital has appointed Miss Mercedes M. Breen, R.N., as supervisor of the pediatric clinics and children's health instruction as a part of its program in pediatric work. Miss Breen has had broad experience as a teacher and as a public health nurse.

Auxiliary to Furnish New Building.—The Florence Nightingale Federation (the women's auxiliary), the Methodist Episcopal Hospital, Brooklyn, is furnishing the new 100 bed maternity building. One of the first steps taken towards acquiring the necessary funds is a concert to be given February 4, by Mme. Ina Bourskaya, noted Russian mezzo-soprano.

Dedicate Wing of Jewish Hospital.—The Jewish Hospital, New York, recently dedicated its new private wing, donated by the family of the late Abraham Abraham, after whom the wing is named. The building is six stories and contains seventy-six private rooms. Plans are also being made for the new maternity wing to be named for the late Dr. Louis Lourie.

Special Studies in Rockefeller Hospital.—The hospital of the Rockefeller Institute for Medical Research announces that the following conditions are being studied in that hospital and that patients suffering from the diseases named will be admitted to the extent of hospital facilities: (1) chronic cardiac diseases, patients showing a complete irregular pulse and fillibration of auricles are especially desired; (2) rheumatic fever, patients should be referred early in the course of the disease; (3) chicken pox; (4) acute pulmonary infections, including acute lobar pneumonia; (5) nephritis, particularly in young persons. Cases showing edema are especially desired.

Ohio

Middletown Opens Training School.—Middletown Hospital, Middletown, announces that a training school for nurses will be opened February 1.

New University Hospital.—Plans have been completed for the new 350-bed hospital to be known as the University Hospital, Columbus. Professor Joseph W. Bradford, State University, Columbus, is the architect. S. R. Hatfield is superintendent.

Starling-Loring Hospital.—A new hospital to be known as the Starling-Loring Hospital, is to be erected in Columbus. It will have a capacity of 100 beds. All laboratories will be in a separate building now under construction. J. N. Bradford, Ohio State University, is the architect. Dr. E. F. McCampbell is the superintendent.

Work Begun on Maternity Hospital.—Excavation has begun on the new Cleveland Maternity Hospital which is to consist of two buildings, to have a capacity of 120 beds, together with a 140-bed babies' and children's hospital. The exterior will be of stone, steel skeleton with tar and gravel and slate roofing. Abram Garfield, Cleveland, is

the architect. Dr. S. S. Goldwater, New York, N. Y., is the consultant.

Pennsylvania

Enlarge Suburban General Hospital.—An addition will be erected at the Suburban General Hospital, Bellevue.

Drive for Livingston Memorial Hospital.—A drive has been launched for the proposed Livingston Memorial Hospital, Pittsburgh. The institution will contain 100 beds and will serve both white and negro patients.

Open New Nurses' Home.—The new nurses' home, Harrisburg Hospital, Harrisburgh, was opened to the public January 1. Fifty-four individual rooms for nurses occupy the four sleeping floors of the five-story building. Each floor contains a study room and adjoining kitchenette. The assembly room, five class rooms, the office of instructor and an infirmary are provided on the first floor.

South Carolina

Plan Tuberculosis Camp.—The Charleston City Council, Charleston, has recently voted the establishment of a tuberculosis camp on a fifty acre tract of land in the county. The conditions state that the camp should be established within one year and be of sufficient size to care for not less than twenty-five free patients.

Tennessee

Addition to Erlanger Hospital.—The Erlanger Hospital, Chattanooga, is to be enlarged, it is announced.

Greater Hubbard Hospital Opened.—The Greater Hubbard Hospital of Meharry Medical College, Nashville, was recently dedicated.

Miss Atkinson Goes to Memphis General Hospital.—Miss Winifred W. Atkinson, formerly connected with the St. Luke's Hospital, Utica, N. Y., has accepted the position of superintendent of nurses, Memphis General Hospital, Memphis.

Texas

Mr. Jolly Marries.—Announcement has been received of the marriage of Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, and Mrs. Lillie E. Burnett, superintendent of nurses, Baptist Hospital, which took place Tuesday, January 1, 1924. Mr. and Mrs. Jolly will reside at 1106 Louisiana, Houston.

Virginia

New Johnston-Willis Hospital Opened.—The Johnston-Willis Hospital, Richmond, was recently formally opened in its new quarters. The new building is six stories high and will accommodate 125 patients.

McGuire Clinic Opened.—The McGuire Clinic, in conjunction with St. Luke's Hospital, Richmond, was recently opened following the remodeling of the building. The department of surgery, gynecology and urology will be in charge of Dr. Stuart McGuire and Dr. Garnet Nelson.

Washington

New Pavilion for Oakhurst Sanatorium.—A new sixteen bed ward for children has been added to Oakhurst Sanatorium, Elma, under the auspices of the Kiwanians.

Open Sanatorium at Foot of Cascades.—A sanatorium has been opened by Dr. Albert Lessing, Leavenworth, at the foot of the Cascade mountains.

Monroe Hospital Sold.—The Monroe Hospital, Monroe, has been sold by Drs. Charles J. Soll and Herman K. Stockwell to Drs. Allison, Tacoma, and James A. Durant,

Snohomish.

To Take Charge of Veterans' Hospital.—Dr. Leon M. Wilbur has gone to Tacoma to take charge of the neuropsychiatric U. S. Veterans' Hospital under construction at American Lake.

Nurses' Home for Children's Hospital.—The cornerstone was recently laid for the Frances Skinner Edris Memorial Home for Nurses of the Children's Orthopedic Hospital, Seattle. The building is being erected to the memory of Mrs. Edris, a former trustee, who did much to promote the erection of a new nurses' home.

Enlarge Cushman Hospital.—The Cushman Hospital, Tacoma, known as the U. S. Veterans' Bureau Hospital No. 59, has been enlarged to care for disabled ex-service women in the Northwest. Two buildings have been set aside for former nurses, yeomanettes, telephone operators and other women enlisted in the army and navy. One section will be used for tuberculous cases and the other for psychiatric cases.

Wisconsin

Diabetic Sanatorium Opens.—The Milwaukee Sanatorium for Diabetes was recently opened.

Canada

Erect Six New Buildings.—Plans are being prepared for the erection of six buildings which will constitute the 800-bed Hospital Des Incurables, Cartierville, Que. The hospital is in charge of the Sisters of La Providence. Veau & Venne, Montreal, are the architects.

Nurses' Drive for Swimming Pool.—The nurses in training at the Royal Alexandria Hospital, Edmonton, Alta., are making a drive for a swimming pool for their home at an estimated cost of $5,000. The nurses of the institution are taking sole charge of the project.

Waterloo County House of Refuge.—Excavation is under way for a new hospital and residential building for the Waterloo County House of Refuge, Kitchener, Ont. W. C. Cowan, Kitchener, is the architect, and E. A. Greutzner, chairman of the building committee. H. W. Martin is superintendent of the institution.

New Tuberculosis Dispensaries.—Dispensaries for the treatment of tuberculous people in the province of Quebec will be established soon throughout the province. The dispensaries will be located in hospitals already established or in other institutions. The government does not intend to erect buildings of its own. School dispensaries are to be established in Montreal and Quebec where nurses and physicians will be trained.

Foreign

New Casualty Department for Royal Northern Hospital.—The foundation stone was recently laid for a new casualty department for the Royal Northern Hospital, Holloway, England.

New Hospital at Puerta Castilla.—A new hospital is under construction at Puerta Castilla to replace the one now in operation. The new institution will have approximately 240 beds.

Open Miners' Hospital for Caerphilly.—The miners' hospital, Caerphilly, England, has recently been opened. The hospital accommodated twenty-one patients and was built at a cost of $30,000.

Plan Children's Hospital.—Bacolod, P. I., is one of the first towns in the islands to open a hospital exclusively for children. Money for the institution was obtained by popular subscription. Dr. Vincente Locsin is in charge of the institution.

New Anti-Tuberculosis Dispensary.—A new free anti-

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tuberculosis dispensary was recently opened at Buenos Aires, under the auspices of the Argentine Anti-tuberculosis League. The president of the republic and *Senora de Alvear* were present at the opening ceremonies.

New Hospital for China.—The new South Manchurian Railway is erecting a three-story hospital in southern Manchuria of from six to eight units, which will accommodate about 300 patients. The hospital will be for the use of the Japanese as well as the Chinese people in South Manchuria.

Appointments in the Canal Zone.—Capt. Henry J. Hayes, M. C., U. S. Army, has been assigned to duty at Corozal Hospital; Major J. M. White, M. C., U. S. Army, at the Ancon Hospital, and Lieut.-Col. S. J. Morris, M. C., U. S. Army, has reported for duty as department medical inspector and assistant to the department surgeon, Col. Henry Webber, M. C., U. S. Army.

Government Hospital Service.—The insular government of the Philippines is planning to provide public hospitals, it is reported, in all provinces of the archipelago, and a large appropriation has been made for that purpose. A hospital committee has been appointed under the chairmanship of Col. E. L. Munson to study plans of organization, and administration of provincial hospitals.

Fresh Air Colony for Children.—The anti-tuberculosis center including a dispensary, a sanatorium for women and a small open air hospital for children slightly infected with tuberculosis has been established at St. Chamend, France, at an altitude of 3,600 feet above sea level. It acts as a preventorium by giving a very effective fresh air cure to 700 children sent from the St. Chamend dispensary.

Hospital Additions in Santiago, Chile.—The charity commission of Santiago has been authorized to raise and expend 2,500,000 pesos in finishing and equipping the pavilions of the Manuel Arriaran Children's Hospital, and the maternity section of the St. Vincent de Paul Hospital, and in adding to the maternity section of the San Borja Hospital so that the school of obstetrics and child care may be installed there.

Spain Has Asylum for Physicians' Orphans.—There are now 102 inmates of the *Colegio del Principe de Asturias*, Spain, which was instituted six years ago for the care of orphans of physicians. The expenses of the institution are defrayed by a stamp tax on medical certificates. Preference is given to children who have lost both parents and to younger children in the family, when the mother is living. Each of the provinces of Spain is entitled to a proportional number of places in the *Colegio*.

Status of Public Hospitals in Peru.—Public Hospitals in Peru are owned and controlled by national benevolent societies (*Sociedad de Beneficencia Publica*), which exist in all the capitals of the provinces of the republic. They are highly charity hospitals with limited pay wards and are supported by revenue received from lotteries and real estate donated to the institutions by the government. Most of their hospital supplies are purchased in the United States. The army hospital and subordinate hospitals are under the supervision of the health department of the Peruvian army and navy.

American Chinese to Erect Hospital.—Chinese people of North America have raised a fund of $110,000 under the stimulus of Miss Lynne Lee Shew for the building and equipment of a 100-bed hospital to be known as the Heung Shew Benevolent Hospital, Skekki Kwang Fung province, China. The hospital is to consist chiefly of ward accommodations supplied in buildings of two stories. Work on the hospital will begin next spring.

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We refer you to St. Joseph's Hospital, Mason City, Iowa, and others.

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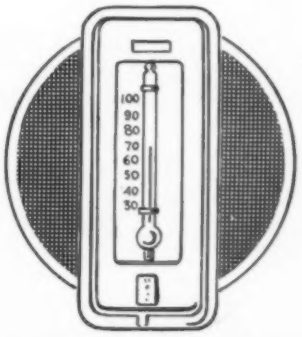

Trade News and Publications

Pix Catalogue of Equipment.—A new catalogue of equipment has recently been issued by Albert Pick & Company, Chicago, Ill. The catalogue is attractively bound and contains thirteen sections under which their equipment is classified. Articles of equipment manufactured by the company are illustrated and described in the catalogue.

Vulcan Bulletin.—The Vulcan Bulletin is the name of the booklet published in the interest of the gas fraternity by the William Crane Company, New York, N. Y.

New Lighting Fixtures.—Hyperion Units, published by the Gill Glass Company, Inc., Philadelphia, Pa., illustrates several new designs in practical hospital lighting glass bowls.

Cleaning Silver.—The American Laundry Machinery Company of Cincinnati, Ohio, has recently published an attractive booklet on this problem under the title of "The Appeal of Gleaming Silver."

Describes Refrigerating Machine.—Bulletin No. 70, issued by the York Manufacturing Company, illustrates and describes their self-contained refrigerating machine especially adapted to hospital usage.

Water Softening and Filtration.—"Water Softening and Filtration" is the name of a thirty-two page booklet recently issued by the Wayne Tank and Pump Company, Fort Wayne, Ind. The booklet contains much information on water softeners and pressure filters of value to hospitals, hotels and other institutions where laundering is an important phase of management.

Honeywell Heating Specialties.—Temperature regulars, one day clock thermostat, radiator valves, water regulars and other useful items are described in the new catalogue of the Honeywell Heating Specialties Company, Wabash, Indiana.

Paint Saves Lives.—"Paint Saves Lives" is the name of an interesting booklet distributed by the National Clean Up and Paint Up Campaign Bureau, St. Louis, Mo. It gives some interesting data on the sanitation of keeping your building painted.

Water System Treatment.—The Perolin Company, Chicago, Ill., has recently issued a booklet describing "Formet," their product for the elimination and prevention of rust, corrosion and discoloration of water in the water supply and hot water heating system.

Whip-All Mixer.—Air-O-Mix Incorporated, Wilmington, Del., in their booklet "Air-O-Mix" describe the many uses of their electric mixer, the "Whip-All Mixer," in the kitchen. This machine is a combination of mixing and aerating and is therefore of special value in mixing egg and milk drinks.

Issue Vacuum Cleaning Bulletin.—"Vacuum Cleaning Data for Architects and Engineers" (fifth edition) is the name of the bulletin recently issued by the United Electric Company, Canton, Ohio. The bulletin contains nineteen pages filled with graphs, pictures, and statistical data concerning vacuum cleaning.